



NATIONAL AIDS COMMITTEE

# BENIN UNGASS REPORT

## 2005



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**Annex 3:** National Return Forms for programme, knowledge, behaviour and impact indicators (through CRIS)

## **DEFINITION OF ACRONYMS**

<b>ARV</b>	: Anti Retro Virals
<b>ADB</b>	: African Development Bank
<b>BHAPP</b>	: Benin HIV/AIDS Prevention Program
<b>WB</b>	: World Bank
<b>MAC</b>	: Municipal AIDS Committee
<b>DAC</b>	: Departmental AIDS Committee
<b>ITC</b>	: Information and Treatment Centre
<b>NAC</b>	: National Aids Committee
<b>CRIS</b>	: Country Response Information System
<b>CRS</b>	: Catholic Relief Services
<b>VAC</b>	: Village AIDS Committee
<b>WF</b>	: World Fund
<b>STI</b>	: Sexually Transmitted Infection
<b>MCAT</b>	: Ministry of Culture Arts and Tourism
<b>MCPD</b>	: Ministry in Charge of Planning and Development
<b>DOW</b>	: Doctors of the World
<b>MHESR</b>	: Ministry of Higher Education and Scientific Research
<b>METFP</b>	: Ministry of Technical Education and Vocational Training
<b>MFPSS</b>	: Ministry of Family, Social Protection and Solidarity
<b>MFPTRA</b>	: Ministry of Civil Service, Labour and Administrative Reform
<b>DWB</b>	: Doctors Without Borders
<b>MPH</b>	: Ministry of Public Health
<b>LSO</b>	: Launch Support Organization
<b>CBO</b>	: Community-Based Organization
<b>NGO</b>	: Non-Governmental Organization
<b>UNAIDS</b>	: Joint United Nations Programme on HIV/AIDS
<b>CSO</b>	: Civil Society Organization
<b>CBAAP</b>	: Community-Based AIDS Action Plan
<b>SPNSAP</b>	: Support Project for the implementation of the National Strategic AIDS Plan.
<b>MDP</b>	: Municipal Development Plan

<b>NAP</b>	: National AIDS Programme
<b>UNDP</b>	: United Nations Development Programme
<b>MAP</b>	: Multisectoral AIDS Project
<b>PSI</b>	: Population Services International
<b>PLHIV</b>	: People Living with HIV
<b>AIDS</b>	: Acquired Immunodeficiency Syndrome
<b>PS/NAC</b>	: Permanent Secretary of the National Aids Committee
<b>NPS</b>	: National Permanent Secretary
<b>AFG</b>	: AIDS Focus Group
<b>UNDF</b>	: United Nations Development Fund
<b>UNICEF</b>	: United Nations Children's Fund
<b>USAID</b>	: United States Agency for International Development
<b>HIV</b>	: Human Immunodeficiency Virus

# 1 STATUS AT A GLANCE

Benin does not yet fall within the countries most seriously affected by HIV/AIDS. Out of a population of 7.5 million inhabitants in 2005, the prevalence of HIV/AIDS among adults aged between 15 and 49 years old is estimated at 2.0%, i.e. approximately 66,000 HIV-positive people. Great geographical differences exist within the country; the prevalence in 2004 varied from 0.3% to 3.3% depending on the department. There is also a higher prevalence in specific groups such as sex workers (27.9%) and tuberculosis patients (16.7%).

In Benin, HIV is mainly transmitted sexually (92% of cases) and from mother to child (6%) and only to a lesser extent through blood transfusions and traditional practices such as tattooing, scarification, circumcision and excisions (2%)<sup>1</sup>.

Access to the prevention service is still low because the sexual health programmes (such as the distribution of male and female condoms, treatment of sexually transmitted infections, HIV/AIDS screening, sex education at school, etc.) do not meet the real needs of the population. Nevertheless, the Reproductive Health Act of 3 March 2003 granted married women access to modern methods of contraception without their husbands' authorization.

In 2001 Benin officially opted for an antiretroviral (ARV) access strategy that included young children, and triple therapy became a reality from February 2002; there are now 43 medicine distribution sites and 4,022 patients receiving treatment. Clinical and biological criteria were established for the commencement of treatment, which distinguish between children under 18 months and over 18 months. From 10 December 2004, ARV treatment was declared free. However, a recent study shows that access remains far from being free.

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<sup>1</sup> NAP et al, 1998

## 2 OVERVIEW OF THE AIDS ENDEMIC IN BENIN

### 2.1 General Presentation of the Country<sup>2</sup>

The Republic of Benin is situated between Niger and Burkina Faso to the north, with the Federal Republic of Nigeria to the East, Togo to the West and the Atlantic Ocean to the south with a 120 km<sup>2</sup> wall. It has a surface area of 114,763 Km<sup>2</sup>.

Geographically it is not very mountainous; its landscape is comprised of a sandy coastal strip followed by two massive plateau areas of Atacora to the north where the rivers have their source.

Two types of climate are observed:

- In the south, a subequatorial climate characterized by two wet seasons (April to July and October to November), and;
- In the north, a tropical climate which is not very humid, with a wet season (May to October) and a dry season (November to April).

Two great basins irrigate Benin, the Niger basin and the coastal basin. The Niger basin receives water from three rivers: the Mékrou, the Sota, and the Alibori. As regards the coastal basin, it receives a great deal more water, notably from the Ouémé, Couffo and Mono rivers. All of these rivers of the coastal basin lead to the sea.

The vegetation is characterized by two elements:

- The vegetation in the Sudanese regions which is present in the north with a wooded savannah dominated by méré, karité, caécédrat, baobab and kapotier trees;
- The weak vegetation of South Benin which extends from the coast to the Setto region in Zou.

All along the rivers, forests and teak, cashew and mango plantations grow.

In administrative terms, Benin has been divided into 12 departments since 15 January 1999. These are Alibori, Atacora, Atlantique, Borgou, Couffo, Collines, Donga, Littoral, Mono, Ouémé, Plateau and Zou.

The country's dominant economic activity is farming, which is carried out by 56% of the working population. The main food-producing crops grown are maize, yam, manioc, groundnut plants, beans, millet and sorghum. Exported crops include cotton, coffee, palm kernels and palm oil.

The secondary sector contributes to only 13% of the gross domestic product (GDP) compared to 52% for the tertiary sector and 35% for the primary sector.

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<sup>2</sup> INSAE (2001): 2001 Demographic and Health Survey

Benin is classed among the poorest countries in which 33% of its population live on less than one dollar a day. The global poverty threshold (GPT) which was established at 42,075 CFA francs per year per capita in 1994-95 rose to 51,513 CFA francs in 1999-2000: an increase of 22%. In a rural setting the GPT is 74,297 CFA francs and in an urban setting it is 91,705 CFA francs. While it is clear that poverty is more rife in a rural and peri-urban setting, it should nevertheless be noted that in terms of depth and severity, poverty is worse in an urban setting<sup>3</sup>.

In the 2002 General Population and Housing Census, a population of 6,769,914 inhabitants was counted with 38.9% living in an urban area and 61.1% in a rural area. This population is mostly female: 51.5% women compared to 48.5% men. The male population ratio is 94.2 men to 100 women. For the year 2005, this population was estimated at 7,492,929 inhabitants<sup>4</sup>.

When divided into broad age groups, it is shown that 15 to 49 year-olds represent 43.8%, 23.6% of which are female. In relation to the total population, 15 to 24 year-olds represent 18.0% and 25 to 49 year-olds 25.6%.

The national literacy rate still remains low at 37.7% in 2002; just under 2/3 of the Beninese population is illiterate. An imbalance in literacy can be noted in favour of men. The male literacy rate is 48.2% while the female rate is 28.1%, i.e. a gender equality index of 0.58.

It should also be noted that the fertility level in Benin remains high, despite the fact that it is falling. Indeed, the synthetic fertility index is 5.3 children per woman, which is below the Niger SFI of 1998 (7.5), borders that observed in Togo (5.4 in 1998), and is above that of Cameroon and the Ivory Coast (5.2 in 1998) and Gabon (4.3 in 2000) obtained from Demographic and Health Surveys.

In terms of health, the coverage of health infrastructures was 87% in 2004 for the first level facilities (District Health Centres/Community Health Centres). For the reference facilities, it is 74% for the Area Hospitals and 83% for the Departmental General Hospitals<sup>5</sup>. The private facilities are found on all levels of the health pyramid.

The 2004 epidemiological profile was characterized by the dominance of endemoepidemic ailments such as malaria (37% of the cases recorded), acute respiratory disorders (16%) and gastrointestinal disorders (7%).

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<sup>3</sup> Paper on the Poverty Reduction Strategy in Benin, 2003-2005, published in 2002

<sup>4</sup> INSAE (2002): Third General Population and Housing Census of February 2002 in Benin

<sup>5</sup> Statistical yearbook of the Ministry of Public Health year 2004

## 2.2 Epidemiological Situation of HIV

### 2.2.1 History of the Epidemic's Evolution since the Appearance of the First Case

The first case of AIDS appeared in Benin in 1985. According to the data from the sentinel surveillance set up in 1990, the prevalence of HIV infection has continued to grow, rising from 0.3% in 1990 to 4.1% in 1999. This surveillance system was based on 11 sentinel sites all of which were urban.

In 2002, a national HIV prevalence survey was organized and conducted on 18,000 pregnant women across 36 towns in Benin. This survey which covered both urban and rural areas gave a prevalence of 1.9%.

The lessons learnt from this survey enabled the representativeness of the sentinel surveillance sites to be improved, which increased from 11 to 45 in both urban and rural areas. There are two types of serosurveillance sentinel sites:

- Prenatal consultancy sites therefore the maternity hospitals of medical facilities throughout the territory (Community and District Health Centres, Private or Denominational Health Centres);
- STI consultancy sites located in the six (06) former departments. This year, the data from the STI sites were not taken into account because not enough samples were taken during the period.

### 2.2.2 The General Current Prevalence and its Evolution

In 2003 and 2004, the prevalence given by the "new formula" sentinel surveillance was 2.0%. Table 1 shows that the HIV infection prevalence estimated in 2003 in 39 sentinel sites and that estimated in 2004 in 46 sites, is situated at the same level as that measured by the 2002 national serosurveillance survey.

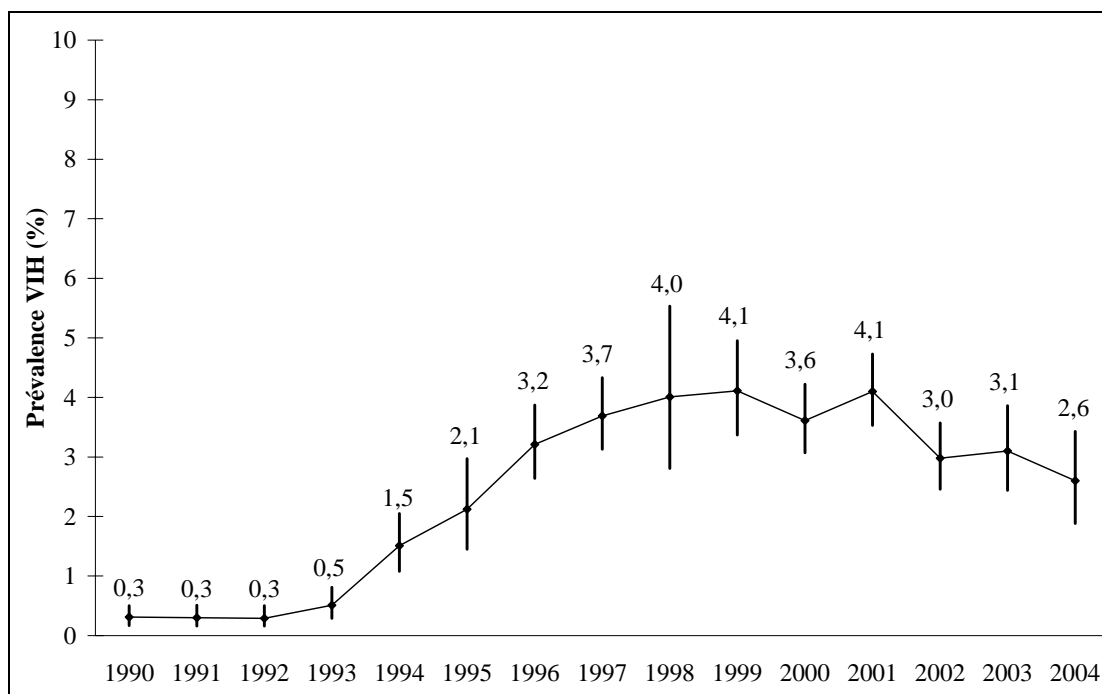
Table 1: Comparison of the 2003 to 2004 HIV infection prevalences

Years	Number of sites	Number surveyed	Prevalence (%)	CI at 95%
2003	39	9,084	2.0	1.90 - 2.10
2004	46	7,447	2.0	1.89 - 2.03

Source: 2004 Serosurveillance Report, NAP

Figure 1 shows the evolution of the prevalence for the 7 former urban sentinel sites. Since 1996, the level of the epidemic in these urban sites has fluctuated between 3 and 4% and the same trend is observed on a national scale. In fact, the weighted prevalence is stable between 2003 and 2004. There is no significant difference according to the area of residence during this period (prevalence in an urban area: 2.8% versus 2.4% and in a rural area 1.6% versus 1.3%).

Figure 1: Evolution of HIV prevalence (and CI at 95%) in the seven urban sentinel sites among Benin prenatal patients from 1990 to 2004



Source: 2004 Serosurveillance Report, NAP

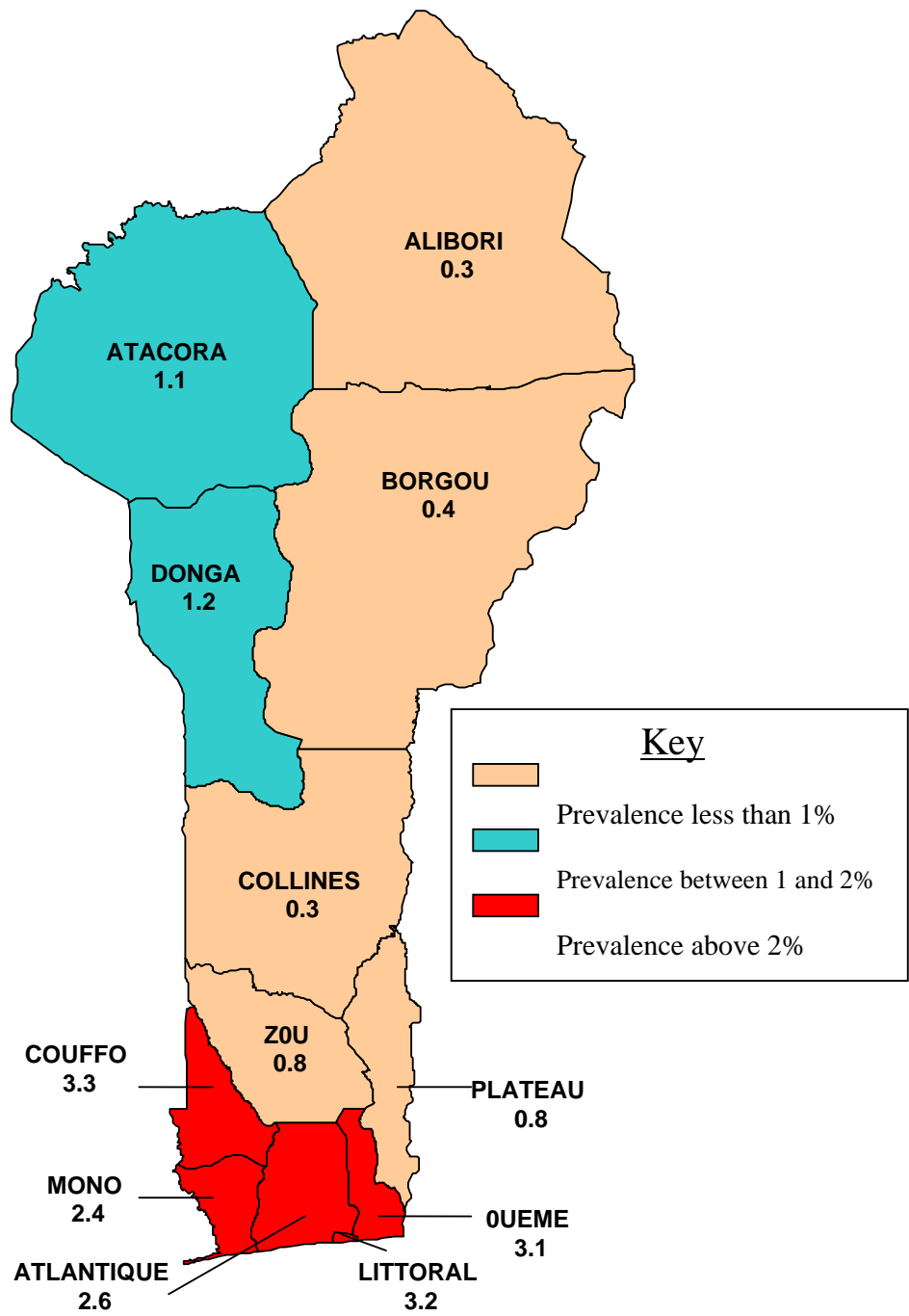
### 2.2.3 Regional Differences of the Epidemic

The national prevalence hides differences both at residential area level and departmental level. It is higher in an urban area (2.4%) than in a rural area (1.6%).

According to the WHO classification which divides the areas into three groups, the departments which have indicative prevalences here, are regrouped into three categories:

- The departments with a prevalence less than < 1.0%: Alibori, Borgou, Collines, Plateaux and Zou;
- The departments with a prevalence between 1.0% and 2.0%: Atacora and Donga;
- The departments with a prevalence higher than 2.0%: Couffo, Mono, Atlantique, Littoral and Ouémé.

Figure 2: Classification of the departments by HIV prevalence in accordance with the WHO standards



Source: 2004 Serosurveillance Report, NAP

Table 2: HIV infection prevalence per department and according to area of residence in 2004

Departments	Urban <sup>a</sup>	Rural <sup>a</sup>	Both <sup>b</sup>	CI 95%
Borgou	0.5	0.3	0.4	0.28 - 0.44
Alibori	1.4	0.0	0.3	0.26 - 0.37
Atacora	2.0	0.6	1.1	1.00 - 1.28
Donga	1.7	1.0	1.2	1.01 - 1.36
Atlantique	2.3	2.8	2.6	2.36 - 2.81
Littoral	3.2 <sup>c</sup>	-	3.2	2.86 - 3.55
Zou	1.9	0.3	0.8	0.54 - 1.08
Collines	1.2	0.0	0.3	0.24 - 0.34
Mono	2.6	2.3	2.4	2.16 - 2.64
Couffo	2.3	3.6	3.3	3.01 - 3.59
Ouémé	3.7	2.5	3.1	2.84 - 3.31
Plateau	1.9	0.3	0.8	0.53 - 1.07
<b>BENIN <sup>d</sup></b>	2.4	1.6	2.0	1.89 - 2.03

<sup>a</sup> Data weighted according to the population's division by age;

<sup>b</sup> Data weighted according to age and the respective weight of the rural and urban areas;

<sup>c</sup> Particular case of Cotonou: purely urban area;

<sup>d</sup> Data weighted according to age, the respective weight of the rural and urban areas and the demographic weight of the departments.

Source: 2004 Serosurveillance Report, NAP

## 2.2.4 Situation of the High-Risk Populations

The high-risk populations considered are sex workers and their clients, lorry drivers, blood donors, young people and tuberculosis patients.

### o Sex Workers (SWs) and their Clients

The estimated prevalence in 2004 (27.9%) is twice as low as that found by the national survey organized in 1999 (55%).

According to the preliminary results of the BSSB (behavioural surveillance survey in Benin) organized in November 2004, the HIV infection prevalence within this high-risk group was estimated at 27.9% in 2004 with notable regional variations as shown in table 3. Regardless of the department, at least 20% of SWs surveyed were

infected with HIV. In the Ouémé/Plateau and Atlantique/Littoral departments, three out of ten SWs were infected with HIV.

Table 3: Estimated prevalence among SWs according to the former departments in 2004

Departments	SWs Surveyed	Infected with HIV		CI at 95%
		Number	%	
Borgou / Alibori	240	64	26.7	21.10 – 32.30
Atacora / Donga	121	28	23.1	15.59 – 30.61
Atlantique / Littoral	525	160	30.5	26.56 – 34.44
Mono / Couffo	127	25	19.7	12.78 – 26.62
Ouémé / Plateau	178	60	33.7	26.76 – 40.64
Zou / Collines	84	19	22.6	13.66 – 31.54
<b>Benin</b>	<b>1,275</b>	<b>356</b>	<b>27.9</b>	<b>25.44 – 30.66</b>

Source: 2004 Serosurveillance Report, NAP

Regarding the SWs' clients, the HIV prevalence for the same survey was 4.3%. It varies from 1.7% to 6.9% according to the departments.

Furthermore, according to the results of the basic studies conducted by the regional AIDS project, along the Abidjan-Lagos Corridor, the HIV prevalence in February 2005 was 8.4% for all of the target groups. It is estimated at 30.1% for sex workers compared to 5.0% for long-distance lorry drivers, 6.6% for adolescents and young people aged 13-35 years old and 8.0% for uniformed personnel<sup>6</sup>.

### o Blood Donors

During the year 2004, 100% of the 58,574 blood bags collected were tested for HIV. Among them, 1,098 were HIV positive, i.e. 1.9% compared to 2.5% in 2003. This rate varies from 1.1% to 2.7% according to the departments.

Table 4: Rate of HIV infection from blood bags

Years	Number of blood bags tested	Number of positive tests	Prevalence (%)	CI 95%
2003	38,869	988	2.5	2.34 - 2.66
2004	58,574	1,098	1.9	1.79 - 2.01

Source: 2004 Serosurveillance Report, NAP

<sup>6</sup> OCAL (Abidjan-Lagos Corridor Organization) (2005), basic studies along the Corridor, biological section

## o Tuberculosis Patients

HIV infection is a factor that encourages the reappearance of tuberculosis. The HIV infection rate among M+PT tuberculosis patients was 16.7% in 2004 compared to 18.5% in 2003. No statistically significant differences can be noted between these two prevalences.

The HIV infection rate among bacilliferous tuberculosis patients (M+PT) at the Cotonou National Hospital of Pneumo-Phtisiology and the Akron Pneumo-Phtisiology Centre in Porto-Novo in 2003 and 2004 is presented in table 5. These two Departmental Treatment Centres deal with approximately 50% of M+PT sufferers treated in Benin.

Table 5: HIV infection among M+PT tuberculosis patients in Cotonou and Porto-Novo from 2000 to 2004.

Years	Number tested	Number of positive tests	Prevalence (%)	CI 95%
2003	357	66	18.5	14.46 - 22.52
2004	937	156	1.7	14.26 - 19.04

Source: 2004 Serosurveillance Report, NAP

## 2.2.5 HIV Prevalence in People Screened Voluntarily

The number of people who voluntarily agreed to take part in the voluntary screening following informed consent has continued to rise as shown in table 6 below. This indicates populations' ever increasing awareness and desire to find out their serological status.

Table 6: Distribution of the number of people who voluntarily agreed to be screened according to the departments in 2005.

Departments	Number tested	Number of positive tests	Prevalence
Atacora / Donga	6,453	59	0.9%
Atlantique / Littoral	31,723	1,212	3.8%
Borgou / Alibori	6,384	9	0.1%
Mono / Couffo	7,167	315	4.4%
Ouémé / Plateau	18,994	211	1.1%
Zou / Collines	12,127	61	0.5%
Benin	82,848	1,867	2.3%

Source: 2005 NAP Monitoring Evaluation

## 2.2.6 Sexually Transmitted Infections (STIs)

According to the SNIGS report, 33,218 cases were reported in 2004, which are divided among the departments as follows:

Table 8: Number of STI cases reported in 2004

Department	Number of cases	Incidence
Alibori	3,623	65.1
Atacora	1,846	31.5
Atlantique	3,566	41.7
Borgou	3,960	51.2
Collines	4,030	70.4
Couffo	1,192	21.3
Donga	1,977	52.9
Littoral	5,725	80.6
Mono	1,387	36.1
Ouémé	2,992	38.3
Plateau	760	17.5
Zou	2,160	33.7
<b>Benin</b>	<b>33,218</b>	<b>46.0</b>

Source: MPH (2004): Health Statistics Yearbook

More specifically, regarding syphilis among pregnant women, the national prevalence in 2004 was 1.1%. This prevalence remains relatively low, close to that obtained during the 2003 survey (1.5%).

Table 9: Prevalence of syphilis among pregnant women

Year	2003		2004		
	Area of residence	Weighted prevalence (%)	Confidence interval at 95%	Weighted prevalence (%)	Confidence interval at 95%
Urban		1.5	1.4 - 1.6	1.07	0.98 - 1.16
Rural		1.5	1.4 - 1.6	1.12	1.06 - 1.20
Benin		1.5	1.4 - 1.6	1.1	1.05 - 1.16

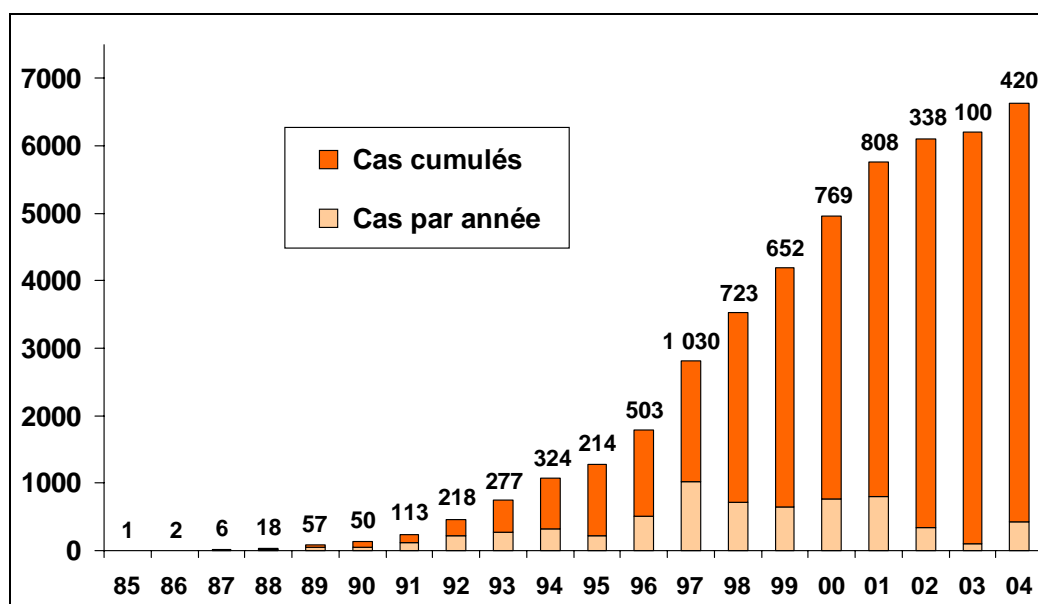
Source: NAP 2003 and 2004 Monitoring-Evaluation Report

### 2.2.7 Reporting of Cases of AIDS

The number of cases of AIDS reported generally far from reflects the reality of the disease in Benin. In 2004, 420 cases were reported.

Since the appearance of the first case of AIDS, the total number of cases has reached 6,623, 6,203 of which were reported up until 2003 and the evolution of the reporting of cases since 1985 is as follows:

Figure 4: Evolution of the number of cases of AIDS reported from 1985 to 2004



### 2.2.8 Forecasts

The estimations are very useful for planning for preventive needs and treatments. However, they remain dependent on the quality of the hypotheses entered into the software.

The main variables retained by the NAP relate to the transmission of the virus and the consequences of HIV infection. Therefore in 2004, the figures expected by the NAP are shown in table 10.

**Table 10:** Estimations for the year 2004 and forecast for 2010

Variables	2004 Estimations	2010 Forecast
Number of people living with HIV / AIDS	79,240	78,255
Children under 15 years living with HIV	6,350	6,172
Adults aged 15 years and over requiring ARV	11,643	11,645
Children under 15 years requiring ARV	2,003	2,272
Number of people infected recently requiring ARV	5,942	5,779
New cases of HIV infection	7,740	9,510
New cases of AIDS	8,270	8,261
Deaths due to AIDS	7,930	8,325
Total deaths due to AIDS	52,030	102,590
Newly infected children aged 0 to 4 years	1,948	1,711
Number of mother or father orphaned children	43,070	47,750
Number of mother or father orphaned children (due to AIDS)	6,540	6,650
Joint HIV / Tuberculosis infection	13,750	16,223
Life expectancy at birth without ARV (in years)	54	56.4
Number of HIV-positive pregnant women	7,160	6,294

Source: 2005 NAP Monitoring-Evaluation

### **3 NATIONAL RESPONSE TO THE EPIDEMIC**

Benin has a national strategic HIV/AIDS/STI framework which defines the driving principles, broad guidelines, objectives, strategies and priority actions for combating AIDS for the 2002-2006 period. All of those involved are working to ensure that it is effectively applied to bring down the infection's progressive trend.

The strategic plan's priority strategic focuses are as follows:

- Strengthening the institutional framework with the creation of the Multisectoral National AIDS Committee including civil society and presided by the Head of State and with the strengthening of the coordination and monitoring/evaluation framework to operationalize the "Three Ones".
- Extension of sexual HIV transmission prevention with increased awareness / communication interventions and the promotion of condom use.
- Improvement of STI treatment through a syndromic approach and improvement of the capabilities of the health personnel.
- Implementation of the mother-to-child HIV transmission reduction programme; extension of the PMTCT sites is in progress.
- Improvement of blood transfusion safety and universal precautions to prevent blood transmission, (improvement of the capacities of the laboratories and blood transfusion services, training / awareness raising for care workers and those involved in the traditional environment).
- Improvement of the screening and medical care received by PLHIV/AIDS (expansion of the sites for treatment of opportunistic infections and via ARV is underway) within the context of the "Three by Five".
- Development of psychosocial treatment for people infected and affected (community-based care through NGOs and ombudspersons, support for Orphans and Vulnerable Children).
- Development of second generation epidemiological monitoring with improvement of sentinel serosurveillance through extension to the rural sites, the study of other surveillance groups (STI, SWs, long-distance lorry drivers) and behavioural surveillance.

#### *Outline of the HIV/AIDS Interventions*

##### **3.1 Strengthening the Institutional Framework**

The majority of the development partners have integrated a STI/HIV section into their programmes, which fall within the national strategic HIV/AIDS framework in Benin.

Combating HIV/AIDS falls within the national strategic poverty reduction framework (PRSP) and the heavily indebted poor countries (HIPC) initiatives framework.

The Cabinet has taken concrete measures to step up the fight against HIV/AIDS by developing budget lines within the ministerial departments concerned and using part of the external debt reduction to create a national AIDS fund.

It is in this way that national HIV/AIDS resources increased from 80 million per year before the strategic planning process to two (02) billion in 2001 by using part of the debt to combat AIDS (HIPC fund).

The process of integrating the HIV dimension is continuing with the strengthening of the institutional implementation capacity, consultation and discussions with more structured groups, unions, employers' associations, government adoption and the integration of the HIV/AIDS dimension in the interim paper (PRSP).

Many actions have been initiated, planned and carried out in accordance with the National Strategic HIV/AIDS Framework. These different actions fall within the domains defined in the national strategic HIV/AIDS/STI framework.

### **3.2 *Communication for Behaviour Change and the Promotion of Condom Use***

Several players, including PSI/ABMS, the Corridor Project, the Africare/BHAPP Project, the AIDS 3 Project, the MAP, the SPNSAP and AFGs are becoming involved in this domain to assist the NAP.

#### **3.2.1 Interventions Directed at the General Public**

##### ***a) Mass Mobilization***

The mass mobilization activities are organized during world AIDS days and large traditional or religious gatherings. Furthermore, 1,560 villages across 57 of the country's 77 towns have benefited from awareness raising campaigns through almost 2,000 Community-Based STI/HIV/AIDS Action Plans. These plans, drawn up by the Communities have directly mobilized 10,000 people, 3,000 of whom are women as well as local administrative authorities and elders.

Social marketing of condoms: in 2004 PSI/NGO distributed 9,580,800 condom units across 16,000 outlets set up in the national territory.

##### ***b) Mass Media Campaign***

In collaboration with the national and community radio stations (Love and Life radio programmes). In this domain, the NAC has signed agreements with 24 community radio stations, whose presenters have been trained in producing interactive programmes to the benefit of the populations covered. Six (06) audio-visual documentaries have been produced and are being broadcast on public and private television channels. Moreover, huge billboards have been erected targeting the general population but above all the mobile populations.

### **3.2.2 Intervention Directed at High-Risk Groups**

#### *a) Local Awareness Raising Activities*

The awareness raising activities have been carried out through the peer educators' strategy in collaboration with NGOs and community groups. During the 2004-2005 period 2,692 peer educators were trained. A local communication programme was developed in Borgou through the community-based services offered by 62 trained community health workers known as *relais communautaires*. Anti-HIV/AIDS communication activities have been carried out on the borders of Togo (Hillacondji) and Nigeria (Sèmè Kraké).

#### *b) Mass Media Campaigns*

They consist of radio programmes and the production of magazines on the sexual behaviour of educated young people (Love and Life), it involves:

- the creation of a radio station and television channel for and presented by young people (ADO-FM);
- the erection of huge billboards targeting the mobile populations;
- the training of teachers and the introduction of curricula dealing with HIV/AIDS in primary and secondary schools (number of teachers trained and number of primary schools).

It should also be noted that anti-aids clubs have been set up in the majority of the country's school establishments.

### **3.2.3 Impact of the Interventions**

The data from the 2004 BSS enable changing behavioural trends to be assessed, particularly among young people and lorry drivers. The proportion of young people able to correctly identify at least 3 ways of preventing HIV infection has increased in a school environment, while it remains the same or lower among uneducated young people. This trend is observed in both rural and urban areas. This level is on the whole low for all young people.

As regards sexual behaviour, the proportion of young people who have been sexually active in the last 12 months who used a condom during their most recent sexual relation whether with a sex worker or not remains the same among educated young people and tends to have increased among uneducated young people. The average age at which young people have sex for the first time remained the same in all groups, and is situated between 16.5 and 17.2 years old.

**Table 1: THE 2001 & 2005 BSS-BENIN INDICATORS – BOTH SEXES IN BENIN**

No.	Indicator	Definition	15-24 years							
			Pupils/Students				Uneducated Young People			
			Boys		Girls		Boys		Girls	
			2001	2005	2001	2005	2001	2005	2001	2005
1	Knowledge of HIV prevention methods (use of a condom, fidelity, reduced number of partners)	Proportion of people able to correctly identify at least three ways of preventing HIV infection	20.0% (322/1609)	31.4% (442/1406)	26.0% (414/1593)	33.5% (479/1428)	10.1% (157/1548)	10.3% (140/1365)	20.8% (617/2962)	9.1% (125/1379)
12	Use of a condom during the last sexual relation with a sex worker	Proportion of young people who have been sexually active in the last 12 months who used a condom during their most recent sexual relation with a sex worker during the period	63.6% (28/44)	54.8% (17/31)	60.0% (33/55)	46.3% (31/67)	65.2% (45/69)	65.3% (49/75)	52.8% (149/282)	57.0% (73/128)
12b	Use of a condom during the last sexual relation with a non-sex worker	Proportion of young people who have been sexually active in the last 12 months who used a condom during their most recent sexual relation with a non-sex worker during the period	59.1% (298/504)	59.5% (285/479)	53.1% (358/674)	51.8% (342/660)	38.5% (205/532)	42.0% (232/552)	27.7% (415/1502)	36.8% (255/693)

### 3.3 Treatment of STIs

STIs are treated within the framework of the curative care service minimum package of the public health-care facilities. They are also treated in private and denominational health-care facilities.

Concerning the coordination and organization of STI control activities, a standards and procedures document for the treatment of STIs was drafted in 2004 and made available to health service managers. Moreover, the training kit was also revised in 2004 in order to better conform to the training standard for adults. Finally, the STI treatment algorithms were revised in 2005 to take into account new WHO recommendations and the evolution of the epidemiological profile of STIs in Benin. Therefore, in terms of strengthening capacities, 61 agents (doctors, midwives and nurses) were trained in clinical training skills and 45 agents from the same categories were trained in supervision.

Nearly 500 agents from the peripheral levels of the public and denominational private facilities were trained in the syndromic treatment of STIs.

Regular supervision is organized in certain departments to improve the health agents' performances in treating STIs and to improve the availability of STI medication.

### 3.4 Prevention of Mother-to-Child Transmission of HIV

An institutional and regulatory framework relating to the PMTCT interventions was set up by Ministerial Order in June 2003. In May 2005, 114 maternity hospitals were involved in the PMTCT and extension of the programme to other health centres within the country is planned.

The PMTCT which did not exist in 2002 is now operational in several maternity hospitals or sites within our country, and at the end of the year 2004 45 sites were already set up in 20 of our country's 34 health areas.

Table: Prevention of Mother-to-Child Transmission (PMTCT)

	Number of women received for first PNC (The first 3 quarters 2005)	Number of pregnant women screened HIV positive in the PNC (The first 3 quarters 2005)	Number of HIV positive women receiving ARV treatment for PMTCT (The first 3 quarters 2005)
Atacora / Donga	2,379	15	9
Atlantique/ Littoral	26,874	597	464
Borgou / Alibori	6,718	140	92
Mono / Couffo	4,914	184	170
Ouémé/ Plateau	4,668	132	102
Zou / Collines	5,659	103	102
<b>Benin</b>	<b>51,212</b>	<b>1,171</b>	<b>939</b>

Source: Monitoring Evaluation Service / NAP 2005

On 30 September 2005, 51,212 women were received for their first consultation at the PMTCT sites; 1,171 women, i.e. 2.28% of them were screened HIV positive; 939 (i.e. 80.2%) of these pregnant women screened HIV positive benefited from ARV

treatment to reduce their viral load and reduce the risk of mother-to-child transmission of HIV/AIDS.

### **3.5 ARV Treatment for PLHIV**

#### **3.5.1 Voluntary HIV Screening**

Voluntary HIV screening is organized around fixed sites which can be either specific screening sites or sites treating PLHIV. In 2005, 28 screening sites were set up and made operational.

Mobile screening campaigns are also organized every year in all of Benin's departments.

**Table 11:** Evolution of the number of people screened from 2003 to 2005

<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>
24,132	34,185	64,068	82,848*

Source: NAP Monitoring Evaluation Third quarter report, 30 September 2005\*

Eighty (80) social and health agents were trained in counselling techniques. On 30 September 2005, 270 agents were trained.

In December 2004, the standards and guidelines for the treatment of PLHIV were drawn up by the NAP and approved by a facilitator.

#### **3.5.2 Implementation of the Antiretroviral Access Strategy**

In 2001 Benin officially opted for an antiretroviral (ARV) access strategy that included young children and triple therapy became a reality from February 2002. The number of sites has increased from 7 in 2002 to 43 at the end of 2005 with 4,022 patients receiving treatment on 30 September 2005 (see table 12).

Clinical and biological criteria were established for the commencement of treatment, which distinguish between children under 18 months and over 18 months. From 10 December 2004, ARV treatment was declared free. In 2004, the NAP drafted and had approved the procedures and standards for ARV treatment of PLHIV.

PLHIV are treated on all levels of the health pyramid in accordance with well-defined criteria. The number of treatment sites increased from 7 in 2002 to 43 in 2005. 122 doctors, 787 nurses and midwives and 26 laboratory technicians were trained in treating PLHIV.

Table 12: Number of people under ARV treatment according to the departments

Departments	PLHIV under ARV
Atacora-Donga	204
Atlantique-Littoral	2,144
Borgou-Alibori	294
Momo-Couffo	520
Ouémé-Plateau	594
Zou-Collines	265
<b>Total</b>	<b>4,022</b>

Source: NAP Benin Third quarter report, 2005\*

On 30 September 2005, 6789 patients benefited from treatment for opportunistic diseases. According to the NAP report, on 31 December 2004, three thousand five hundred and eight (3,508) patients were treated for opportunistic diseases.

### 3.5.3 Support for Orphans and Vulnerable Children

A census of two thousand three hundred and sixty-four (2,364) orphans and vulnerable children was made at the end of 2004 throughout the national territory. Among this number, one thousand one hundred and twenty-six (1,126) are provided with schooling or are apprenticed and only three hundred and twelve (312) are living with a foster family.

Two hundred and eighty-seven (287) foster families have been counted, two hundred and twenty-two of which benefit from support in terms of food products. In total, one thousand and sixty-eight (1,068) orphans and vulnerable children benefit from support in terms of food products.

It is important to point out that thanks to the support of the World Bank, UNICEF, the NGO Benin Plan and the Catholic Relief Services (CRS), the PS/NAC, the MPH, and the MFPSS organized a National Workshop on the situation of OVC in May 2004. One of the main recommendations of this workshop was to conduct a study on the situation of OVC.

### 3.5.4 Collaboration with Traditional Therapists

The collaboration between modern medicine and traditional medicine has been strengthened.

Thus, 135 traditional therapists have been trained within the context of the trainers' training. The training modules concerned general STI/HIV/AIDS issues, diagnosis, prevention, psychosocial treatment of patients and collaboration between modern and traditional medicine. This training was conducted by the MPH and supported by the MAP.

The Partners supporting Benin in the domains of medical, psychosocial and nutritional care are the UNAIDS, the World Fund, the World Bank, UNICEF, the French Cooperation, GIP/ESTHER, the Canadian Cooperation, the Swiss Cooperation, Africare/BHAPP, DWB, APH/Gohomé, CRS, Benin Plan and the denominational hospitals.

### ***3.6 Prevention of Blood-Borne Transmission of HIV***

During the year 2004, 100% of the 58,000 blood units collected were screened for HIV.

Twenty-four (24) laboratory technicians were trained in the quality of the services and seventy-one (71) others were trained in HIV and blood transfusion safety.

### ***3.7 HIV Prevention in the Workplace***

In 2004, using financing from USAID and the International Labour Office (ILO), Benin implemented a new project for AIDS prevention and control in the workplace through the Ministry of Civil Service, Labour and Administrative Reform (MFPTRA). The objective of this project called ILO/USDOL, is to support Company Directors in setting up AIDS control action plans within their respective organizations.

Therefore, during the year 2004, a three-party State-Employer-Union declaration was adopted outlining the actions to be carried out.

In this way, the ILO/USDOL project initiated its activities in the following organizations: SBEE, FLUDOR, IBCG, CODA-Benin, COLAS, SATOM, CPA, MFPTRA, SOGEA, SCB.

On 31 December 2004, 33 operational AFGs each managed by an office with an average of 10 members, mobilized over 30,000 people in the Ministries, State Institutions, Offices and Public and Private Companies.

The AFGs have also distributed over 500,000 male condom units in the workplace benefiting staff from the Ministries, Institutions and Offices.

## **4 MAJOR CHALLENGES FACED AND ACTIONS NEEDED TO ACHIEVE THE GOALS/OBJECTIVES**

Two categories of challenges were faced during the implementation of the national programmes: institutional problems and those linked to the implementation of the actions.

### ***4.1 The Institutional Problems***

- Poor level of operationalization of the "Three Ones" principles.
- Poor leadership of the coordination facilities in the mobilization of resources and creation of synergies between the actions carried out in the country.
- Constant interference of the roles of the coordination authority and the execution facilities.
- Insufficient human, material and financial resources to ensure the normal operation of the coordination facilities both at national and decentralized level.

### ***4.2 Problems Linked to Implementation***

- Instability of the staff at the facilities charged with combating HIV/AIDS.
- Insufficient human resources within the context of treatment.
- Persistent stigmatization and discrimination of PLHIV and SWs.
- Under-financing of the HIV/AIDS control activities in Benin within the context of the planning of the projects.
- Lack of HIV/AIDS impact studies on the different sectors of the national economy.
- Poor level of nutritional care for PLHIV.
- Delay in applying the legal provisions on HIV/AIDS, particularly in terms of discrimination and stigmatization.

- The scheduled end of certain projects, the actions of which have greatly contributed to increasing the control of the epidemic:
  - French Cooperation project in December 2005;
  - World Fund Support in July 2006.
  - BHAPP project in May 2006;
  - AIDS 3 project in September 2006;
  - ILO/USDOL project in July 2006;
  - Multisectoral AIDS Project (MAP) in September 2006.

### *4.3 Actions Needed*

- Raise the awareness of those involved for the effective implementation of the "Three Ones".
- Strengthen the leadership of the coordination facilities for a better synergy between the actions carried out and for the mobilization and allocation of resources.
- Clarify the roles of the coordination authorities and the execution facilities.
- Strengthen the coordination authorities both at national and decentralized level by granting them material, human and financial resources appropriate to their assignment.
- Make the staff at the facilities charged with combating HIV/AIDS more stable.
- Intensify the communication for behaviour change actions with a view to reducing the stigmatization and discrimination of PLHIV and sex workers.
- Carry out a better evaluation of the projects with a view to granting them sufficient resources.
- Initiate HIV/AIDS impact studies on the different sectors of the national economy.
- Promote nutritional care for PLHIV.
- Ensure the effective application of the legal provisions on HIV/AIDS, particularly in terms of the discrimination and stigmatization of PLHIV.
- Mobilize resources for future projects.

## **5 SUPPORT REQUIRED FROM COUNTRY'S DEVELOPMENT PARTNERS**

The national strategic HIV framework has served as the centre for all of the interventions implemented in the country by both the national and international players.

The following table reviews the support required from the country's development partners in terms of actions carried out and those envisaged for the future.

Table 14: SUPPORT REQUIRED FROM PARTNERS

<b>DOMAINS OF THE ACTIVITIES</b>	<b>FOCUSES OF THE INTERVENTION</b>	<b>ACTIONS ENVISAGED</b>	<b>SUPPORT REQUIRED</b>
INSTITUTIONAL FRAMEWORK	Coordination Advocacy Monitoring and evaluation	Effectively implement the driving principles - "Three Ones"	Increase the institutional capacities Effectively adhere to the "Three Ones" principles Support the national monitoring and evaluation system
COMMUNICATION FOR BEHAVIOUR CHANGE	Promotion through communication to raise awareness and encourage behaviour change in the population in general  Reduction in the prevalence of HIV/AIDS infection in children aged between 10 and 24 years old  Increase rural and urban women's capacities to become involved in the fight against STI/HIV-AIDS  Reduction in the prevalence of STI/HIV-AIDS within the mobile populations  Reduction in the prevalence of STI/HIV-AIDS among sex workers and their clients	Support the drafting of a Communication Policy and Strategy national document  Support the drafting of a Communication for Behaviour Change Strategy national document  Support the drafting of training modules in the local languages and social mobilization actions  Support the activities that generate revenue in the direction of young people and women	Consulting services Human resources Material resources Financial resources
PROMOTION OF CONDOM USE	Increase the rate of condom use	Strengthen the promotional activities Mass media campaigns, interpersonal communication Ensure the availability of male and female condoms	Consulting services Human resources Material resources Financial resources
PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV	Voluntary screening during PNC  Treatment of HIV-positive pregnant women  Monitoring of newborns	Extend the PMTCT sites to all districts  Equip the sites with equipment and consumables	Consulting services Human resources Material resources Financial resources

<b>DOMAINS OF THE ACTIVITIES</b>	<b>FOCUSES OF THE INTERVENTION</b>	<b>ACTIONS ENVISAGED</b>	<b>SUPPORT REQUIRED</b>
		Equip the treatment sites with ARV, paediatric presentation  Integrate PMTCT into Reproductive Health	
PREVENTION OF BLOOD-BORNE TRANSMISSION OF HIV	Systematic testing of blood bags in all blood banks	Provide all blood banks with reagents and consumables  Increase the blood storage capacities with a view to a safe blood policy  Strengthen the actions to increase the number of blood donors and develop their loyalty	Human resources Material resources Financial resources
CORRECT TREATMENT OF PLHIV	Treatment of opportunistic infections  Psychological treatment  ARV treatment  Nutritional care	Extend the Treatment sites to all districts  Equip the sites with equipment and consumables  Equip the treatment sites with ARV for a larger number of patients Train the medical staff in better treatment of PLHIV	Consulting services  Human resources  Material resources  Financial resources
EPIDEMIOLOGICAL MONITORING AND RESEARCH	Monitoring of trends and behaviours regarding STI/HIV-AIDS  Promotion of bio-medical research  Optimization of the reliability of the epidemiological monitoring of HIV-AIDS	Organize second generation surveillance surveys  Increase the promotion of bio-medical research  Strengthen the epidemiological monitoring system Train the staff involved in conducting the serosurveillance studies	Consulting services  Human resources  Material resources  Financial resources
HIV / AIDS PREVENTION IN THE	Improvement of the national legislation with a	Popularize national legislation on	Convert the current ILO project into a

DOMAINS OF THE ACTIVITIES	FOCUSES OF THE INTERVENTION	ACTIONS ENVISAGED	SUPPORT REQUIRED
WORKPLACE	<p>view to protecting workers' rights</p> <p>Communication for Behaviour Change in the workplace centred around peer education</p>	<p>HIV-AIDS and ensure that it is applied in the workplace</p> <p>Strengthen the actions in partner companies. Extend the interventions to other workplaces</p>	<p>Sustainable Programme</p> <p>Strengthen the human, material and financial resource capacities</p>

## 6 MONITORING AND EVALUATION ENVIRONMENT

In the drafting of the 2002-2006 National Strategic HIV/AIDS Framework, the national monitoring and evaluation system was not clearly taken into account or even formulated as a domain. Nevertheless, in the implementation of the framework, the need to have an information collection tool for all of the national-level activities carried out proved to be a requirement. Moreover, it is for this reason that at NAC level, a unit called the **National Monitoring and Evaluation Unit** run by a unit head has been set up. In order to meet this requirement, in addition to the efforts made by each project and programme, the NAC initiated the national monitoring and evaluation system in 2004.

The operational handbook for the national monitoring and evaluation system which is currently being drawn up covers the 2007-2011 period and includes the following elements: a data collection and analysis strategy, a well-defined standardized set of indicators, guidelines on tools for data collection, a strategy for assessing the quality and accuracy of the data and a data dissemination and use strategy. Given that the drafting process for the national monitoring and evaluation system has not reached its conclusion, the provisions relating to the financing of the activities contained in this plan have not yet been clearly defined.

**Major stages of the implementation process for the national monitoring and evaluation system for STI/HIV-AIDS activities.**

- Support from several consultants (CRIS Unit - the UNAIDS Country Response Information System, GAMET);
- Adoption of the main actions with the support of the consultant with a view to implementing the national monitoring and evaluation system for AIDS activities;
- Analysis of the existing system;
- Recruitment of a national consultant to assist the process;
- Drawing up of the conceptual framework;
- Consensus on the national indicators;
- Creation of the collection tools;
- Definition of the data collection system;
- Consolidation of the results and drafting of the monitoring and evaluation handbook;
- Approval of the national monitoring and evaluation plan;
- Drawing up of the implementation plan;
- Approval of the implementation plan.

At the current stage of the process's implementation, the operational handbook for the national monitoring and evaluation system has been drawn up and is awaiting approval.

In fact, the national monitoring and evaluation unit of the Permanent Secretary of the National Aids Committee has drawn up divisions at decentralized level (department, town, district and village). It is assisted by a national advisory group comprised of all of the monitoring and evaluation managers of the projects and

programmes, representatives from research institutions, civil society and associations for PLHIV.

The national monitoring and evaluation system relies on the other already existing sectoral monitoring and evaluation systems. The latter provide data to all levels of the pyramid. This data is processed using monitoring and evaluation software.

One of the important results of this monitoring and evaluation mechanism was the definition of a list of 19 indicators taken from the UNGASS list of indicators. In fact this entire process was supported by a national advisory group.

At national level, the monitoring and evaluation unit uses the CRIS to process the data and calculate the indicators. To strengthen this system, certain needs should be taken into account.

- The need to integrate the monitoring and evaluation system into the new national strategic STI/HIV/AIDS framework.
- The need for training.
- The need for financial resources for data collection and use.
- Material needs above all at decentralized level.