AFRICAN DEVELOPMENT FUND

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APPRAISAL REPORT

HIV/AIDS CONTROL SUPPORT PROJECT

BENIN

SOCIAL DEVELOPMENT DEPARTMENT
CENTRAL AND WEST REGIONS

OCSD
April 2004

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This report was prepared by Mrs. B. BA, Health Analyst (OCSD.2) and two consultants, following a Bank preparation/appraisal mission in February 2004. All questions should be referred to Mr. P. T. SEYA, Division Manager, OCSD.3 (Ext. 2173).

AFRICAN DEVELOPMENT FUND

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PROJECT INFORMATION SHEET
Date: February 2004

The information given hereunder is intended to provide some guidance to prospective suppliers, contractors, consultants and all persons interested in the procurement of goods and services for projects approved by the Boards of Directors of the Bank Group. More detailed information may be obtained from the Executing Agency of the Borrower.

1.	COUNTRY	:	Republic of Benin
2.	NAME OF PROJECT		HIV/AIDS Control Support Project
3.	GEOGRAPHICAL LOCATION	:	The 6 Communes of Savalou, Natitingou, Porto Novo, Parakou, Comé and Ouidah
4.	BENEFICIARIES	:	Members of the PS/CNLS and the populations in the communes of Savalou, Natitingou, Parakou, Come and Ouidah
5.	EXECUTING AGENCY	:	Ministry of Planning and Development (MCPPD) Project Management Unit located in the premises of the Permanent Secretariat of the HIV/AIDS Control Committee (SP/CNLS) 08 BP 259 Tel: 229-30-52-58

6. PROJECT DESCRIPTION

The project will support preventive actions, traditional medicine and the coordination and implementation capacities of the national framework for HIV/AIDS control. The project has three components as follows: support to preventive activities (epidemiological surveillance, IEC, testing and PRETRAME) and traditional medicine, (ii) support to the structures responsible for HIV/AIDS control; (iii) project management. The project categories can be summarized as follows:

A) Goods
B) Services
C) Operating expenses

7.	TOTAL COST		:	UA 2 840 000
	i)	Foreign exchange	:	UA 1 400 000
	ii)	Local currency	:	UA 1 440 000
8.	BANK GROUP FINANCING			
	Grant		:	UA 2 700 000
9.	OTHER SOURCES OF FINANCE:			
	Government		:	UA 140 000
10.	PROBABLE APPROVAL DATE		:	30 June 2004
11.	ESTIMATED START-UP DATE & DURATION		:	January 2005 – 36 months

12. PROCUREMENT OF GOODS AND SERVICES :

Local shopping: 1 official car, furniture, and equipment for the PMU.
Direct negotiation: with UNIPAC for the procurement of drugs, including ARVs for PRETRAME; with IAPSO for the procurement of equipment (vehicles, computer and IEC) for the PMU, PS/CNLS, CDLS, CCLS, CALS, CVLS and; with UNDP for monitoring/counselling for the PMU, for activities at communal level.
Direct negotiation: with the local staff for trainings, workshops and seminars, IEC/BCC activities, supervision, monitoring/evaluation, study trips and international conferences, overseas training for NGOs and CBOs.
Preparation of short lists: 5 senior PMU staff, ad hoc consultants for the impact, appraisal and evaluation studies, behaviour surveillance surveys, accounting systems, certain IEC activities for implementation by NGOs and CBOs, and project audit.

13. NECESSARY CONSULTANCY SERVICES:

Consultants will be necessary under technical assistance, project management, impact studies, behaviour surveillance survey, certain IEC activities (for implementation by NGOs), the accounting system, audit of UNDP project and services for procurement of goods and services and monitoring/counseling for the PMU.

CURRENCY EQUIVALENTS
(April 2004)

Local currency	=	CFA Franc
UA 1	=	CFA.F 794.462
UA 1	=	USD 1.48051

WEIGHTS AND MEASURES

1 kilometre (km)	=	0.62 miles
1 metre (m)	=	3.28 feet
1 hectare	=	2.47 acres
1 inch	=	2.54 centimetres

FINANCIAL YEAR

1st January to 31st December

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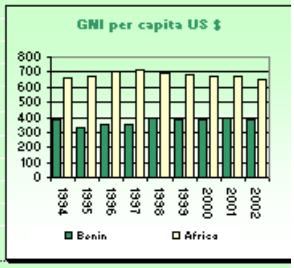
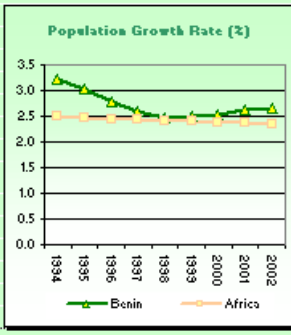
LIST OF ACRONYMS AND ABBREVIATIONS

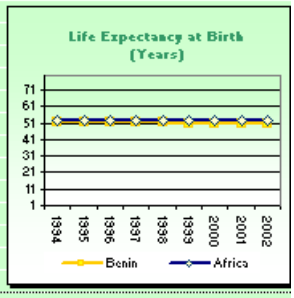
ADF	African Development Fund
AIDS	Acquired Immuno-Deficiency Syndrome
ARV	Anti-retroviral
BCC	Behaviour Change Communication
CALS	District AIDS Control Committee
CBO	Community-based Organization
CCLS	Communal AIDS Control Committee
CDLS	Departmental AIDS Control Committee
CIC	Information and Counselling Centre
CNC	National Coordination Committee for Global Fund-financed Projects
CNLS	National AIDS Control Commission
CQLS	Area AIDS Control Committee
CSP	Country Strategy Paper
CVLS	Village AIDS Control Committee
GTZ	German Cooperation
HIPC	Heavily- Indebted Poor Countries Initiative
HIV	Human Immune Deficiency Virus
IAPSO	Inter-Agency Procurement Services Office
IEC	Information, Education, Communication
IMF	International Monetary Fund
MAP	Multi-Country HIV/AIDS Programme
MCPPD	Ministry of Planning and Development
MDG	Millennium Development Goals
MFPSS	Ministry of Family Affairs, Social Protection and Solidarity
MCTP	Mother-Child Transmission Prevention
MOH	Ministry of Health
MTP	Medium-term Plan
PMU	Project Management Unit
NGO	Nongovernmental Organization
OVC	Orphans and Vulnerable Children
PLWHIV	Persons Living with HIV/AIDS
PNLS	National Aids Control Programme
PPLS	Multi-sector AIDS Project
PRSP	Poverty Reduction Strategy Paper
PS	Permanent secretariat
PSI	Population Services International
ROBS	Network of Beninese NGOs in the Health Sector
SSS	Sero-surveillance system
STI	Sexually Transmitted Infections
UA	Unit of Account
UNDP	United Nations Development Programme
UNESCO	United Nations Educational Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
UNIPAC	UNICEF Procurement and Assembly Center
UNPF	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

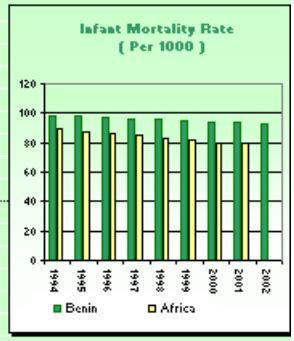
BENIN: SOCIO-ECONOMIC COMPARATIVE INDICATORS

	Year	Benin	Africa	Develo-ping Countrie	Develo-ped Countries
Basic Indicators					
Area ('000 Km²)		113	30 061	80 976	54 658
Total Population (millions)	2002	6.6	831.0	5,024.6	1,200.3
Urban Population (% of Total)	2002	43.1	38.6	43.1	78.0
Population Density (per Km²)	2002	58.2	27.6	60.6	22.9
GNI per Capita (US $)	2002	380	650	1 154	26 214
Labor Force Participation - Total (%)	2002	45.5	43.1	45.6	54.6
Labor Force Participation - Female (%)	2002	48.3	33.8	39.7	44.9
Gender -Related Development Index Value	2001	0.395	0.484	0.655	0.905
Human Develop. Index (Rank among 174 countrie:	2001	159	n.a.	n.a.	n.a.
Popul. Living Below $ 1 a Day (% of Population)	1995	...	46.7	23.0	20.0
Demographic Indicators					
Population Growth Rate - Total (%)	2002	2.6	2.2	1.7	0.6
Population Growth Rate - Urban (%)	2002	4.6	3.9	2.9	0.5
Population < 15 years (%)	2002	46.9	43.2	32.4	18.0
Population >= 65 years (%)	2002	2.8	3.3	5.1	14.3
Dependency Ratio (%)	2002	93.6	86.6	61.1	48.3
Sex Ratio (per 100 female)	2002	96.8	98.9	103.3	94.7
Female Population 15-49 years (% of total populatic	2000	...	24.0	26.9	25.4
Life Expectancy at Birth - Total (years)	2002	50.6	50.6	62.0	78.0
Life Expectancy at Birth - Female (years)	2002	53.0	51.7	66.3	79.3
Crude Birth Rate (per 1,000)	2002	41.5	37.3	24.0	12.0
Crude Death Rate (per 1,000)	2002	14.3	15.3	8.4	10.3
Infant Mortality Rate (per 1,000)	2002	92.7	81.9	60.9	7.5
Child Mortality Rate (per 1,000)	2002	156.0	135.6	79.8	10.2
Maternal Mortality Rate (per 100,000)	1992	500	641	440	13
Total Fertility Rate (per woman)	2002	5.7	4.9	2.8	1.7
Women Using Contraception (%)	1996	16.4	40.0	59.0	74.0
Health & Nutrition Indicators					
Physicians (per 100,000 people)	1999	3.4	57.6	78.0	287.0
Nurses (per 100,000 people)	1995	20.4	105.8	98.0	782.0
Births attended by Trained Health Personnel (%)	1996	60.0	38.0	56.0	99.0
Access to Safe Water (% of Population)	2000	63.0	60.3	78.0	100.0
Access to Health Services (% of Population)	1991	42.0	61.7	80.0	100.0
Access to Sanitation (% of Population)	2000	23.0	60.5	52.0	100.0
Percent. of Adults (aged 15-49) Living with HIV/AID	2001	3.8	5.7	1.3	0.3
Incidence of Tuberculosis (per 100,000)	2000	43.1	198.0	144.0	11.0
Child Immunization Against Tuberculosis (%)	2002	99.0	76.4	82.0	93.0
Child Immunization Against Measles (%)	2002	88.0	67.7	73.0	90.0
Underweight Children (% of children under 5 years	1996	29.2	25.9	31.0	...
Daily Calorie Supply per Capita	2001	2 455	2 444	2 675	3 285
Public Expenditure on Health (as % of GDP)	1998	1.6	3.3	1.8	6.3
Education Indicators					
Gross Enrolment Ratio (%)					
Primary School - Total	2000	95.0	89.2	91.0	102.3
Primary School - Female	2000	78.0	83.7	105.0	102.0
Secondary School - Total	2000	22.0	40.8	88.0	99.5
Secondary School - Female	2000	14.0	38.2	45.8	100.8
Primary School Female Teaching Staff (% of Total)	1998	23.1	49.9	51.0	82.0
Adult Illiteracy Rate - Total (%)	2002	60.3	37.9	26.6	1.2
Adult Illiteracy Rate - Male (%)	2002	45.2	29.2	19.0	0.8
Adult Illiteracy Rate - Female (%)	2002	74.5	46.4	34.2	1.6
Percentage of GDP Spent on Education	1998	2.5	3.5	3.9	5.9
Environmental Indicators					
Land Use (Arable Land as % of Total Land Area)	2002	15.4	6.2	9.9	11.6
Annual Rate of Deforestation (%)	1995	1.2	0.7	0.4	-0.2
Annual Rate of Reforestation (%)	1990	5.0	4.0	...	...
Per Capita CO2 Emissions (metric tons)	1998	0.1	1.1	1.9	12.3









Source : Compiled by the Statistics Division from ADB databases: UNAIDS: World Bank Live Database and United Nations Population Division.
Notes: n.a. Not Applicable ; ... Data Not Available.

PROJECT MATRIX
BENIN AIDS CONTROL SUPPORT

Description	Objectively verifiable indicators	Means of verification	Basic Assumptions
Sector Goal 1. Contribute to reducing HIV/AIDS prevalence	From 2004 to 2007* : 1.1 Mother-child transmission rate reduced by 20% in 2004 to 5% 1.2 Number (N) of voluntary screenings increased by 45%	 1.1.1Country statistics for MCTP 1.2.1Activity reports of screening centres 1.3.1Activity reports of structures providing care	
Project objective 1. Support preventive measures, traditional medicine and the institutions responsible for HIV/AIDS/STI control	The following indicators** achieved between January 2004 and December 2007: 1.1 Mother-child transmission rate reduced in the 6 communes from 20% in 2004 to 5% at project completion 1.2 From 2004 to 2007 screening in the 6 project zones covers 15% of the population (i.e. 106 510 persons tested and aware of their serological status) 1.3 PNLS assesses the prevalence and incidence of HIV/AIDS and behavioural changes in the general population and the target groups every two years (there were no monitoring mechanisms in 2004) 1.4 600 (10%) of traditional doctors trained in the diagnosis, prevention and psycho-social management of PLWHIV. Protocol on the traditional treatment of opportunistic diseases validated and adopted by 2006 (rate was unknown in 2004) 1.5 Indicators (prevalence, incidence etc) and attitudes to AIDS known in farming and teaching communities are known from the results of impact studies conducted in 2006 (no such study undertaken in 2004) 1.6 100% of SP/CNLS officers have been trained in coordination, monitoring/evaluation, microplanning and IEC (no experts trained in 2004) 1.7 100% of training courses undertaken at the decentralized level in the 6 communes and the staff are performing much more efficiently (rare instances of such training in these communes)	 1.1.1Annual MCTP activity reports in the 6 communes 1.2.1 Activity reports of the PNLS and testing centres; national statistics 1.3.1 Survey findings, indicators of behaviour change 1.4.1 Reports of the PNLS and Ministry of Health 1.5.1 Survey reports, behavioral change indicators, PNLS reports 1.6.1 SP/CNLS activity report 1.7.1PNLS reports and project report	1.1.1.1 Capacity constraints of centralized and decentralized HIV/AIDS control institutions 1.2.1.1.Political will to fight HIV/AIDS sustained at the highest level (Government and partners) 1.3.1.1 The central and decentralized structures have an operating budget for HIV/AIDS control 1.4.1.1. Public involvement in the project activities 1.5.1.1. Idem 1.6.1.1. Idem 17.1.1. Idem

Outcomes 1. HIV/AIDS preventive activities intensified at local level 2. Central and decentralized structures supported.	1.1 Over 15% of the population have been tested between 2004 and 2007 1.2 Statistics on change in behaviour are available by end 2006 (none available in 2004) 1.3 Between 2004 and 2007, 100% of women in the 6 communes are using maternity centers (30480 pregnant women) and have access to MCTP 1.4. 100% of preventive activities (IEC, chats, discussions, etc) are effected at the decentralized level and the target population is HIV aware 1.5 Treatment of opportunistic infections by traditional medicine harmonized and is available to 2 700 traditional doctors. 2.1 National monitoring-evaluation system within the PSP/CNLS is established by end 2005 (no M/E system in place in 2004) 2.2 The decentralized structures in the SP/CNLS are functional at 100% (CCLS, CALS, CQLS, CVLS) in the 6 communes by 2005 (no figures available for 204)	1.1.1 CNLS reports 1.2.1 CNLS reports and survey findings 1.3.1 Statistical reports of maternities in the 6 districts, and the PNLS 1.4.1 Reports of the /CNLS and proceedings of the sessions held in the 6 communes 1.5.1 Reports of the Ministry of Health and the PNLS 2.1.1Report of the SP/CNLS 2.2.1 Idem & reports of the PMU	1.1.1.1 The people are aware and participate in project activities 1.2.1.1 Idem 1.3.1.1 Idem 1.4.1.1 Idem 1.5.1.1Partnership between modern medicine and traditional medicine is effective 1.6.1.1 Government continues to allocate resources to SP/CNLS 1.2.1.1. Idem 1.3.1.1. Idem
Activities 1. Goods 2. Services 3. Operations	Budgetary resources in million UA Category FE. LC Total (A) Goods 0.93 0,00 0.93 (B) Services 0.47 1.35 1.82 (C) Operation. 0.00 0.10 0.10 Total 1.40 1.44 2.84		

* Country indicators (culled from Global Fund document) have been extrapolated for 2007 ; **project study will confirm or complete these indicators

EXECUTIVE SUMMARY

1. Background

In Benin, about a third of the population lives below the poverty line. The Government has therefore elaborated a poverty reduction strategy paper for the period 2002 – 2005 which has as its strategic thrust: (i) to strengthen the medium-term macroeconomic framework; (ii) to develop human capital and environmental management ; (iii) to improve governance and institutional capacities ;(iv) to consolidate Benin's macroeconomic stability; (iv) to improve access to basic education, literacy, primary health care, drinking water, and combat HIV/AIDS and malaria ; (v) to fight corruption, consolidate democracy and decentralization,; (vi) promote sustainable employment and increase the poor's capacity to create income-generating activities, and to ensure effective development of the national territory. More specifically, among the quantitative objectives of poverty reduction, Benin aims, by 2005, to reduce the prevalence rate of HIV/AIDS, as well as infant and child mortality from 113.7 to 109.1 for every 1000 live births, and maternal mortality rates from 485 to 475 for every 100 000 live births. The HIV/AIDS prevalence rate in 2002 was 1.9%.

As part of its efforts to combat HIV/AIDS, the Government has drawn up a strategic framework for action against HIV/AIDS (CSLS) which sets out the general objectives, strategies and priority actions. The general objectives of the CSLS- 12 in number- are, inter alia, to: (i) reduce the prevalence of sexually transmitted infections ; (ii) increase the use of condoms ; (iii) make blood transfusions 100% HIV-free ; (iv) reduce the incidence of HIV/AIDS in young people in the 10 to 24 year age bracket ; (v) enhance the capacity of women in rural and urban areas to join in the war against STI/HIV/AIDS ; (vii) ensure that those affected and infected by AIDS are properly catered for. A National AIDS Control Commission (CNLS) has been set up and constitutes the institutional framework and main decision and policy-making body on HIV/AIDS control in the country. The Commission has a Permanent Secretariat and its staff is drawn from the Administration, NGOs and civil society. In pursuit of the above goals, the Government has sought the help of several development partners, including the Bank, to which it submitted a funding request in October 2003. Two Bank missions consequently visited the country in November 2003 and February 2004, to identify and appraise a support project for HIV/AIDS control. The project is in line with Government and Bank policy and strategy papers on HIV/AIDS, health, education and population. The project is also consistent with the DSP (2002-2004) for Benin and with the millennium development goals. Indeed, a key objective of the DSP is the development of human resources and the social sectors, with the battle to contain HIV/AIDS as a major priority. The project will contribute to the attainment of the following three millennium goals: (i) improving maternal health; (ii) reducing under-five mortality and; (ii) reducing the prevalence of HIV/AIDS.

2. Sector Goal

The project sector goal is to contribute to reducing the prevalence of HIV/AIDS. The specific objective is to boost preventive activities, traditional medicine, and the structures that carry out HIV/AIDS/STI control.

3. Project Description

The project has three components: i) support to preventive activities (epidemiological surveillance, IEC, MCTP and testing) and traditional medicine; i) support to the structures responsible for HIV/AIDS/STI control; (iii) project management. The project activities include technical assistance, training, community-based activities, impact studies, ex-ante and ex-post studies, training sessions/study trips, supply of furniture, equipment and ARV/drugs, consumables, and the operating expenses.

4. Project Costs

The total project costs net of taxes and customs duties are estimated at UA 2 840 000, of which UA 1 400 000 is in foreign exchange, i.e. 49%, and UA 1 440 000 in local currency, representing 51% of the entire project cost. ADF contribution represents 95% of the total project cost, while the Government's contribution constitutes 5%.

5. Sources of Finance

The project will be jointly financed by the Grant and the Government of Benin. The total Grant amount of UA 2 700 000, represents 95 % of the total project cost and covers 100% of the foreign exchange costs (UA 1 400 000) and 89 % of the local currency costs. The Government will finance 11% of the local currency costs, corresponding to UA 140 000, which is 5% of the total project cost. Its contribution will be used to finance part of the operating expenses and part of the training costs.

6. Project Implementation

The Project Management Unit will be located in the premises of the PSP/CNLS, which will carry out project supervision and coordination. It will operate with the requisite management and support staff to enable it to function properly. The project and the Government will pay the operating expenses pertaining to project management. The project will also pay for the installation of a computerized account management system and for an annual audit of the project accounts. The Government has promised that it will draw up a manual of administrative and financial procedures modelled on the manuals currently being used in the fight against HIV/AIDS, which it will forward to the Bank not later than three months from the date of first disbursement of ADF funds. The draft of the manual must meet with the Bank's prior approval.

7. Conclusions and Recommendations

Conclusion

The project is in line with the National Strategic Framework for the Control of HIV/AIDS/STI, the PRSP, the CSP and the Bank strategy in the area of HIV/AIDS control. It will help to strengthen the structures that have responsibility for coordinating and implementing HIV/AIDS control activities, namely, the PS/CNLS, the six departmental HIV/AIDS control committees, the six communal HIV/AIDS control committees, the 46 district committees, and the 358 village and zonal committees. The project will also give a boost to the programme to promote the pharmacopoeia and traditional medicine. Through it, 7 500 traditional doctors will be able to take advantage of the research findings on the products identified, their effectiveness, quality and safety, and benefit from the protocol identifying traditional products that have some

efficacy in treating opportunistic infections. 600 of these traditional doctors will be given training in the diagnosis and prevention of HIV/ AIDS, and the psycho-social care of PLWHIV. In addition, 912 parturients and their babies will have access to services that help to prevent mother to child transmission of the virus. Lastly, the project will help to increase the number of people who are tested (106 510).

Recommendations

It is recommended that a grant not exceeding 2.70 million Units of Account be granted to Benin for the implementation of this project.

1. ORIGIN AND HISTORY

1.1 In Benin, (cf Annex 1–administrative map) about a third of the population lives below the poverty line. The Government has therefore prepared a Poverty Reduction Strategy Paper for the 2002-2005 period with, as its strategic thrusts to: (i) strengthen the medium-term macroeconomic framework; (ii) develop human capital and environmental management (including the prevention and control of the diseases earmarked for priority attention: malaria, STI/AIDS and tuberculosis); (iii) promote governance and institutional capacity building ;(iv) consolidate Benin's macroeconomic stability; (iv) improve access to basic education, literacy, primary health care and drinking water, and to control HIV/AIDS and malaria; (v) combat corruption, consolidate democracy and decentralization; (vi) promote sustainable employment and increase the poor's capacity to create income-generating activities and to ensure effective development of the national territory. More specifically, among the quantitative objectives of poverty reduction, Benin aims, by 2005, to reduce the rate of HIV/AIDS prevalence and to lower infant and child mortality from 113.7 to 109.1 for every 1000 live births, and maternal mortality from 485 to 475 for every 100 000 live births.

As part of its efforts to combat HIV/AIDS, the Government has drawn up a strategic framework for action against HIV/AIDS (CSLS), which sets out general objectives, strategies and priority actions. The general objectives of the CSLS- 12 in number- include inter alia, to: (i) reduce the prevalence of sexually transmitted infections; (ii) increase the use of condoms; (iii) make blood transfusions 100% HIV-free; (iv) reduce the incidence of HIV/AIDS in young people in the 10 to 24 age bracket; (v) enhance the capacity of women in rural and urban areas to join in the war against STI/HIV/AIDS; (vii) ensure that those affected and infected by AIDS are properly catered for. A National AIDS Control Commission (CNLS) has been set up and constitutes the institutional framework and the main decision and policy-making body on HIV/AIDS control in the country. The Commission has a permanent Secretariat and staff drawn from the Administration, NGOs and civil society. In pursuit of the above goals, the Government has sought the help of several development partners, including the Bank, to which it submitted a funding request in October 2003. Two Bank missions consequently visited the country in November 2003 and February 2004 to identify and carry out an appraisal on an HIV/AIDS control support project. The project is in line with the Government's and the Bank's policy and strategy papers on HIV/AIDS, health, education and population. The project is also consistent with the CSP (2002-2004) for Benin, and the millennium development goals. Indeed, a key objective of the CSP is the development of human resources and the social sectors, with the battle to contain HIV/AIDS as a major priority. The project will contribute to the attainment of the following three millennium goals : (i) improving maternal health ; (ii) reducing under-five mortality and ; (ii) reducing the prevalence of HIV/AIDS.

2. THE HIV/AIDS PANDEMIC IN BENIN

2.1. HIV/AIDS Situation

2.1.1 The first AIDS case in Benin was reported in 1985. In 2001, UNAIDS estimated at 120 000 the number of persons living with HIV. In 2002, the PNLS (National AIDS Control Programme) published a total number of 6103 reported cases. The 15 to 49 age bracket is the most affected with 85.3% of all cases. Transmission is mainly heterosexual in 89% of cases, and vertical transmission from mother to child accounts for 4% of the cases.

The proportion of women and men infected are now about the same, whereas up until 1996, the ratio was two men for every woman. A survey carried out by the PNLS in 2002 indicated a prevalence rate of 1.7% for syphilis in pregnant women.

2.1.2. In the 2002 UNAIDS report, the prevalence of HIV infections was estimated at 3.6% in the adult population in Benin, compared to the African average of 8.6% (cf Annex 2). The figures provided by PNLS (National AIDS Control Programme) give a prevalence rate of 4.1% in 2001 and 1.9% in 2002. Before deciding which prevalence rate to use, the Bank studied the background to the sero-prevalence situation. The next few paragraphs should provide a clearer understanding as to why there is a disparity in the figures provided by the PNLS.

2.1.3 Data on HIV/AIDS infection in Benin is based on a serological surveillance system (SSS) using sentinel sites, which was established by PNLS in 1990. This system is based on the unlinked anonymous testing of pregnant women attending antenatal clinic (CPN), and patients presenting with STIs (Sexually Transmitted Infections). The network as at now comprises 11 sentinel sites which are State health facilities: 7 maternities and 4 structures for the treatment of STIs. These sites are mainly representative of the urban population. Figures obtained via the sentinel network showed that prevalence had grown from 0.36% in 1990 to 4.1% in 2001, with regional variations of between 2.5% (Atacora) and 7.9% (department of Borgou).

2.1.4 In 2002, the PNLS decided to evaluate the sentinel network sero-surveillance for HIV infection. A cross-sectional study was conducted, covering the twelve departments on the new administrative map of Benin. Thus, 3 communes in each department were chosen at random, making 36 communes in all. In each of the communes chosen, all the prenatal health centres were included, that is to say all the government, private and mission-owned structures. A total of 247 urban and rural sites were covered in the survey. 17650 pregnant women were enrolled whose average age was 25.8 years. The prevalence rate obtained for the country was 1.9% with the rate being lower than 1% in some communes (Perere 0.3%) and others having a prevalence rate above 4% as, for instance, Parakou (6.4%), which is a very big commune and a busy hub through which very many people pass as they carry out their activities which are trading, restauration, hotel management and industrial manufacturing.

2.1.5 The Bank observed that the results obtained using the 'traditional' sentinel surveillance network method (4.1% in 2001) and those from the 2002 survey (1.9%) were incomparable. Thus, surveys conducted since 1990 and the one carried out in 2002 were not on the same scale. There are substantial differences between the two surveillance methods. Firstly, the populations compared are not the same in terms of type or group. The 2002 survey concentrated on pregnant women only, no STI patients were included. Secondly, the surveys were not on the same scale: 7 maternities used in the traditional method and 247 for the evaluation. The geographical representation also was not the same. The traditional system involved only urban dwellers whereas the 2002 survey included rural populations. Moreover, only the public health structures were used in the traditional network whereas private and mission-owned structures were added in the 2002 survey.

2.1.6 This analysis of epidemiological data collection in Benin led us to consider using a prevalence rate of 1.9% as a working basis. This figure was obtained from a large sample of pregnant women representative of the general population. The survey conditions were also technically valid. To date, no other survey has matched the scale of the 2002 survey which

covered the entire country. Unfortunately, the lower prevalence rate might negatively impact on the implementation of AIDS control strategies as it could lead players in the field to consider the AIDS situation in Benin as being less alarming than in other regions of Africa. For this reason, the 4% prevalence should be borne in mind because it reflects the situation in the urban areas where vulnerable groups like sex workers and migrants are not adequately aware of the problem. This being so, and mindful of the need to have reliable data to be able to track the development of the pandemic and the measures being taken, the Bank has highlighted the urgent need to strengthen the sero-surveillance system in Benin. This will require increasing the number of sentinel sites and ensuring a better distribution between the urban and rural areas. In addition, in order to have a more representative mix of the population, it would be necessary, apart from public facilities, to also include private health facilities and those run by denominational organizations.

2.1.7 The surveillance should also be extended to include groups other than pregnant women, and primarily, sex workers, migrants, young people (attending school or not), tuberculosis patients, prison populations etc. It is also vital to include behaviour surveillance surveys. Thus, from the findings of the 2002 survey, the communes concerned by the ADF project are those that have the highest prevalence rates in the 6 chosen departments, namely: Parakou in Borgou-Alibori commune: 6.4%; Comé in Mono-Coffou commune: 5.2%; Ouidah in Atlantique-Littoral commune: 4.3%; Porto-Novo in Ouémé-Plateau commune: 2.7%; Natitingou in Atacora-Donga commune: 2.9%; Savalou in Zou-Collines commune : 1.8%.

2.1.8 An analysis of the general risk factors shows that the disease is spread through having multiple sex partners, insufficient awareness of the risk and the refusal to accept the reality of AIDS, the subordination of women (levirate, etc.), prostitution, high mobility and migration of populations in the sub-region, and poverty. Other aggravating factors are the high female illiteracy (only 22% of women are literate), unwillingness to use condoms, early withdrawal of girls from school (one out of two girls in the 6-14 age group does not attend school), and unwillingness to be tested.

2.2. Institutional framework

Central coordination structures

2.2.1 The central coordination structures are the CNLS (national commission for the control of HIV/AIDS/STI) and its permanent secretariat (PS). The CNLS, which has the Head of State of Benin as the Chair, is the apex body for the multisectoral coordination of HIV/AIDS control in the country. It has three deputy chairpersons, who are, in descending order, the Minister of State for Planning and Development, the Minister of Health, and the Minister of Finance and the Economy. The CNLS meets once a year; its members are all the other cabinet Ministers, the Prefects of the departments, representatives of PLWHIV (people living with HIV), the Medical and Pharmaceutical Corps, the SIDA-BENIN Foundation, the Chamber of Commerce and Industry, the Economic and Social Council, the Conseil National du Patronat (Employers' Association), the Reseau Ethique, Droit et VIH (Ethics, Law and HIV Network), the National Assembly, NGOs working against AIDS, the labour unions, religious communities, youth and women's associations, and traditional healers.

2.2.2 The Permanent Secretariat of the CNLS (PSP/CNLS) functions as the secretariat. It is the technical organ for coordination, technical support and monitoring of all CNLS activities. In that capacity, it (i) coordinates and facilitates implementation of the activities under all projects and structures engaged in HIV/AIDS control, (ii) supervises implementation of all tasks assigned to the CNLS in collaboration with the heads of structures and projects working to combat HIV/AIDS, (iii) together with the relevant national structures, it organizes advocacy to mobilize resources from national and international partners, (iv) and, especially, ensures coherence of all HIV/AIDS control activities in Benin. PS/CNLS was one of the principal dialogue partners during the preparation/appraisal mission.

2.2.3 The PNLS, the ministerial focal points and civil society are the implementation structures of the CNLS. The PNLS is active in the public health sector and provides technical support to other partners operating in the sector. The focal points in the Ministries and the public institutions undertake activities that target their staff and the people they serve. Civil service organizations operate with their members and the target populations in view.

2.2.4 At the time that Benin was preparing its proposal to the Global Fund to fight HIV/AIDS, tuberculosis and malaria, a National Coordination Committee (CNC) was established. Its 46 members are drawn from the United Nations, development partners (bi and multilateral), the coordination structures for action against tuberculosis and malaria, NGOs, civil society, PLWHIV, religious groups and all the other government structures involved in control activities. In common with all the other anti -AIDS structures, this committee is under the supervision of the CNLS.

2.2.5 Traditional medicine occupies a pivotal place in primary health care, and in 1985, the Ministry of Health set up the Department of Research, Medicine and Traditional Pharmacopoeia. The department coordinates and supervises the traditional pharmacopoeia and medicine programme.

Decentralized Structures

2.2.6 AIDS control committees have been established in all the administrative departments, communes, districts, zones and villages. All these arms of the CNLS should make for efficient decentralization of the national response to the pandemic.

2.2.7 The departmental AIDS control commissions (CDLS) are the representatives of the CNLS within the departments. Their work is directed from a permanent secretariat, which is under the authority of the Prefect. The departmental PS elaborates, proposes and submits activity programmes, and the budget to the CDLS. Within the departments, the decentralized structures are the departmental AIDS control unit, the sectoral programmes and the programmes of civil society organisations.

2.2.8 At commune level, the CCLS (communalcommunal AIDS control committees) are the next step down the ladder after the CDLS. Their role is to set general policy and strategic orientations for AIDS control at commune level, to monitor and assess AIDS control activities, and to assist in leveraging resources for implementation of activities within the communecommune. The communal secretariat which oversees the CCLS supports the latter by supervising resource allocation to the different implementation structures, which are the district AIDS control units, the sectoral programmes and those of civil society.

2.2.9 The district AIDS control committees carry out the work of the CCLS at district level. They help to monitor and evaluate the actions taken within the district and to mobilize resources. Zonal or village committees (CQLS / CVLS) are to be established, and will be modelled on the multi-sector village committees which exist already. Their role will be to prepare community-based HIV/AIDS control plans and to source the funds for their implementation.

2.3 National response

Government

2.3.1 The Government of Benin began responding to the HIV/AIDS epidemic as far back as 1987, when it embarked on control and preventive measures. Between 1987 and 2000, three programmes were initiated in collaboration with WHO and other partners. A short-term plan covering the period 1987-1988 addressed urgent issues like safe blood transfusion, information and sensitization. A medium-term plan (MTP1) for the period 1989 to 1993 followed, and this was implemented until April 1996. MTPI concentrated on sero-surveillance, safe blood transfusion, prevention, use of condoms, and information- education-communication (IEC). MTP1 was successfully implemented and made it possible to (i) establish an operational sero-surveillance programme, (ii) ensure safe blood transfusion through the setting up of laboratories with facilities for serology in 4 departments, in addition to the referral laboratory in Cotonou, (iii) elaborate and adopt a country policy paper on blood transfusion; iv) reinvigorate HIV prevention through increased use of IEC, and (v) effectively begin to care for PLWHIV. Unfortunately, the technical consultative commissions of the PLNS, established under MTPI, folded up because of understaffing and also because the structure attempted to implement all HIV/AIDS activities without help from other sectors, and without using a multisectoral approach. In 1996, aware of the multiple dimensions of the AIDS epidemic, Benin drew up the second multi-sectoral mid-term programme (MTP2) which covers the period 1997 – 2001. MTP2 involved the NGOs and development partners. It also built on the successes of PMT1, and laid special emphasis on the control and prevention of STIs, safe blood transfusion, communication /awareness-raising, and effective care of persons living with HIV/AIDS. The PNLS was given additional functions during the implementation of MTP2.

2.3.2 In January 2000, a year before MTP2 ended, the process of elaborating the strategic framework of the national response to HIV/AIDS started. It began with a situational analysis. Then, a detailed review of the national response was carried out. That analysis showed that the most vulnerable groups were women and the youth. It focused attention on the target groups and on the priority areas which were: (i) the youth, (ii) women, (iii) sex workers, (iv) migrants, (v) public enlightenment, (vi) STIs, (vii) sale of condoms, (viii) safe blood transfusion and (ix) care of PLWHIV. The process culminated in the formulation of the national multi-sectoral strategic framework 2001 – 2005. From now on, all control activities must fall within this strategic framework. Eleven general objectives were identified for intensifying HIV/AIDS control, and these are, to: (i) stabilize the prevalence of HIV/AIDS among the youth (ii) mobilize all women in the rural and urban areas to be part of the campaign against STI/HIV/AIDS, (iii) reduce the HIV/AIDS prevalence rate in Benin, (iv) improve safe blood transfusion in Benin, (v) ensure delivery of AIDS-free babies in Benin, (vi) improve epidemiological surveillance of HIV/AIDS, (vii) increase behaviour surveillance, (viii) ensure global and effective care for all PLWHIV, (ix) drastically reduce

STI/HIV/AIDS transmission among the mobile population, (x) reduce STI and HIV/AIDS prevalence among sex workers and their clients, (xi) promote, through communication, increased awareness and appropriation of STI/HIV/AIDS control by the community.

2.3.3 The complex nature of AIDS control activities has prompted political leaders to mobilize action at the national level. In May 2002, the President established the National HIV/AIDS Control Commission (CNLS). Its principal role is in the area of policy orientation for AIDS control but, most especially, the commission is expected to coordinate and supervise all actions undertaken in the context of the national strategic plan. It is also expected to mobilize resources nationally and internationally (cf. paragraph 2.4.1). The PNLS (the executive arm of the CNLS) has prepared a fund mobilization plan for the period 2002–2006. Despite Benin's commitment to combating HIV/AIDS, however, much remains to be done in terms of financial and human resources.

NGOs and Community-based Organizations

2.3.4 Numerous NGOs were involved in AIDS control during implementation of MTP2. Some national NGOs formed a network in a bid to enhance their institutional and technical capacity. For example, the Bank met with the Benin Network of NGOs for Health (ROBS) which has 89 member NGOs across the country. NGO networks assure communities of qualitative service by working within strategic action plans and by being sticklers for good governance and transparent management. Many donor-funded programmes use these types of networks as service providers for their decentralized activities on the ground. International NGOs, too, are active in AIDS control in Benin. They intervene in the fields of prevention, enlightenment, awareness raising, IEC, medical and psychosocial care of PLWHIV, voluntary testing, epidemiological surveillance, STI, sex workers etc… UNDP has carried out an inventory of all NGOs, but regrettably, it was not limited to NGOs in the health sector alone. Given that many NGOs now exist which carry out AIDS control activities exclusively, the survey needs to be updated to show the specific areas in which each intervenes.

2.3.5 Associations of PLWHIV are springing up. They aim to provide mutual assistance and to protect the rights and interests of PLWHIV. They need to become increasingly involved in prevention and enlightenment activities by talking about their experiences. They will thus play an increasingly crucial role in removing stigmatization as they provide psychological and social care and support for sufferers, including visits to their homes.

2.4 Interventions by State and other partners

State-funded activities

2.4.1 At the instigation of the CNLS, the Government has set aside a budgetary appropriation exclusively for use in combating HIV/AIDS. Part of the HIPC funds made available under the debt relief programme has been constituted into a national HIV/AIDS Control Fund. Total national resources committed to AIDS control has grown from CFA.F 80 million a year before the strategic planning process to CFAF 2 billion in 2001. In 2003, the share of the national budget channelled into fighting HIV/AIDS was one billion CFA F, half of the budget for 2001. In 2004, 1.14 billion CFA F from the State budget is being committed to HIV/AIDS control, which corresponds to 0.26% of the general State budget of 546.5 billion CFA F. Government's contribution towards combating HIV/AIDS is as follows: (i) 900 000 000 CFA F allocated to the PNLS; (ii) 200 000 000 CFA F as counterpart funds

to the World Bank-financed PPLS, and; (iii) 40 000 000 FCA F to the Corridor Project funded by the World Bank. The State pays the operating expenses of the SP/CNLS and counterpart funds for ongoing AIDS control projects.

Interventions by development partners

2.4.2 All the development partners have subscribed to the national strategic framework for action against HIV/AIDS/STI, and the partnership against AIDS. UNAIDS has helped to set up the UNAIDS Thematic Group. The group is operational and has a rotating chairmanship. Its members are all the chief executives of the United Nations agencies: UNICEF, UNDP, WHO, UNFPA, UNESCO, WFP, FAO, HCR and the World Bank. Membership is extended to the government and bilateral partners : European Union, USAID, GTZ, French Cooperation, Swiss Cooperation, Belgian Cooperation, Danish Cooperation, German Cooperation, Dutch Cooperation, Canadian Cooperation (CIDA) – AIDS Project III, international NGOs (PSI, Africare, IFESH, World Education, MCDI, Care International, CRS, MSF, etc…), representatives of civil society, the private sector and PLWHIV. The Deputy Chair is held by a bilateral or multilateral partner outside the United Nations system. UNDP has been the Chair since 2003 with USAID as the Deputy Chair. UNAIDS inter-country advisory programme supports the action of the group. The Thematic Group is a key player in advocacy and resource mobilization and it enables effective coordination of the interventions of all donors and development partners. The Bank had an opportunity to observe the dynamism of the Thematic Group at one of the latter's meetings, where constraints to AIDS control was among the issues discussed.

2.4.3 The table below shows interventions by donors.

Table 2.4 : Intervention by partners in HIV/AIDS control activities

Areas of intervention	Partners	Financing in $US	Duration
Intensifying action against HIV/AIDS (**Prevention, testing and care of PLWHIV)**	**Global Fund / UNDP**	**17, 726,161.00**	**2004 to 2007**
Multi-sectoral HIV/AIDS Control Project **(PPLS). Institutional support (SP-CNLS, NLS, Ministries, Communes, CBOs and NGOs), prevention, information, counselling, testing and epidemiological surveillance**	**World Bank**	**23, 000,000.00**	**2002 to 2006**
Transport Corridor Project **/ MAP (Côte d'Ivoire, Togo, Ghana,** Benin **and Nigeria) Prevention, treatment, medical care of STI, Ois, SPS , coordination, capacity –building for policies and strategies**	**World Bank (Financing for / 4 countries)**	**17, 900,000.00**	**2004 to 2007**
Community development Project **(prevention, IEC, capacity building for decentralized agencies and associations, legal framework)**	**UNDP**	**2, 000,000.00**	**2004 to 2008**
Support project for PNLS **institutional support, prevention, education and communication**	**WHO**	**150,000.00**	**2004 to 2005**
UNICEF Programme (Survival, education, protection, monitoring and evaluation) **includes PRETAME, HIV/AIDS control and care of PLWHIV/AIDS**	**UNICEF (Total financing)**	**25, 420,000.00**	**2004 to 2008**
Reproductive health, institutional support **to the Ministry of Health, the Armed Forces and NGOs (prevention, IEC, condoms for/ women and men)**	**FNUAP**	**2, 500,000.00**	**2003 to 2008**
HIV/AIDS prevention technical assistance project (**Prevention, IEC and institutional support for SP-CNLS and PNLS (surveillance)**	**BHAPP / Africare / USAID**	**4,500,000.00**	**2002 to 2006**
HIV/AIDS/STI control project **Prevention, IEC and procurement of condoms**	**PSI / USAID**	**4, 000,000.00**	**2004 to 2005**
Support project to 4 health zones **(prevention, enlightenment, IEC, Training and support for activities on the ground, procurement of condoms/via PSI)**	**GTZ / USAID**	**371,519.46**	**2004**
Support project for HIV/AIDS control in West Africa **Prevention, IEC, testing, and medical treatment of STIs for the TS**	**SIDA 3 / Canada**	**2, 091,138.17**	**2001 to 2006**
Support project for the development, and implementation, of a culturally adapted communication strategy	**Swiss Cooperation**	**108, 277.83**	**2004 to 2006**
Project to strengthen blood transfusion services in the departments	**Belgian Cooperation**	**1.887.925.79**	**2004 to 2006**
HIV/AIDS control support project**(including PRETRAME) Prevention, information, counselling, testing and epidemiological surveillance**	**Coopération Française**	**943.973.98**	**2001 to 2005**
HIV/AIDS control project **Prevention, IEC, counselling, testing and medical treatment of PLWHIV**	**Médecins Sans Frontières France**	**4, 953,592.78**	**2002 to 2007**
Sensitization in dioceses and parishes **on prevention, IEC and Community-based care**	**CRS / CAFOD / SCF - France**	**310,000.00**	**2004 to 2006**
EQUIPE Project (AIDS component) **prevention of blood transmission of HIV/AIDS in clinics run by member NGOs of the ROBS**	**CARE International / USA**	**705,657.41**	**2004 to 2006**
Community development and local initiatives support project	**HCR / Racines**	**12,360.68**	**2004 to 2006**
	Fonds Belge de Survie / FENU (Total financing)	**2.400.000.00**	**2004 to 2006**
TOTAL		111 097 607.	

2.4.4 The total amount made available by donors is not used exclusively for AIDS. Some partners, it should be recalled, allocate only a part of their global financing to the AIDS component. This is true of UNICEF, USAID, and French and Belgian Cooperation – the amounts indicated against their names in Table 2.4 include funds meant for other health sector activities.

2.4.5 Benin submitted a funding request to the Global Fund in September 2002 in respect of its activities to curb HIV/AIDS/STI, tuberculosis and malaria. The request was approved and UNDP was named the executing agency. It will, in that capacity, administer the 17 726 161 US dollars which has been allocated for use over three (3) years (January 2003 – December 2005), for intensifying action against STI/HIV/AIDS. The Global Fund is financing four aspects:: (i) facilitating access to counselling and voluntary testing, (ii) boosting actions to prevent HIV transmission to certain categories of the population (pregnant women, young people, sex workers, transfused patients, people on the move, (iii) improving global care for PLWHIV especially the prevention and treatment of opportunistic infections, and greater access to ARVs, and (iv) mitigating the socio-economic impact of HIV/AIDS on certain particularly affected categories of the population (orphans, PLWHIV).

2.4.6 One of the principal interventions in the effort to curb HIV/AIDS in Benin is the World Bank-financed PPLS (Multisectoral HIV/AIDS Control Project). This project is an initiative of the Beninese Government and the World Bank, and seeks to curtail the spread of the epidemic and mitigate its impact on PLWHIV and affected persons. 23 million US dollars have been made available for a 4 year period. The project, which started up in 2002, covers the entire country and targets all population groups. The funds are made available based on the needs of the different beneficiaries (structures, NGOs, association, Ministries etc.)

2.4.7 The Corridor Project, initiated as part of the World Bank's MAP (Multi-country AIDS Programme), aims to improve access by vulnerable groups to prevention and care of HIV/AIDS along the Lagos-Abidjan Transport Corridor. It is expected to contribute to curbing the spread of HIV/AIDS and mitigating its negative social and economic impact along the transport corridor. The project covers five countries – Côte d'Ivoire, Ghana, Togo, Benin, and Nigeria – and has a budget of 17.9 million US dollars spread over 4 years (2002 – 2006). Roughly 1/5 of the global budget will go to Benin.

2.4.8 The BHAPP project (Benin HIV/AIDS Prevention Project) is a joint initiative of Benin's Ministry of Health and the United States Agency for International Development (USAID). The project has a four-year lifespan and commenced in July 2002 with a budget of 4.5 million US dollars. Its objective is to reduce the HIV/AIDS transmission rate in Benin. In this connection, BHAPP undertook an evaluation and analysis of the HIV/AIDS surveillance system in Benin for the PNLS in 2003. The project has technical assistants working to support the Government in the aspects of epidemiological surveillance. The Bank has noted that the sero-surveillance system in Benin needs to be made more effective, as a matter of urgency.

2.4.9 It is as yet too early to gauge the impact of the above interventions by partners since, apart from four projects which started off in 2001 and 2002, all the other interventions are very recent, having only commenced in 2004. Also, as stated earlier n section 2.1, the variation in the HIV/AIDS prevalence rate (0.36% in 1990, 4.1% in 2001 and 1.9% in 2002) obtained from different non-comparable surveys makes it impossible to determine whether any of these interventions has actually impacted on HIV/AIDS prevalence in any way.

2.5 Constraints to HIV/AIDS Control

At institutional level

2.5.1 As far as institutions are concerned, the Bank noted weak coordination of the actions carried out by the SP-CNLS. This is due, firstly, to the fact that it is inadequately financed. For instance, as at March 2004, no national operating budget had been voted for the PSP-CNLS for the current year. The other reason is a lack of human resources, which militates against effective coordination of all the sectors engaged in AIDS control. The pivotal role of the PS/CNLS needs to be affirmed if the actions undertaken in the different areas of intervention are to be coherent.

2.5.2 The Bank also noted an overlapping in the functions of the PSP-CNLS and the PNLS. The multi-sectoral vision which underpinned the establishment of the CNLS resulted in its being assigned very wide functions. Coordination and supervision at country level, hitherto the remit of the PNLS, have now been assigned to the CNLS. A redefinition of the functions of the PNLS will make it possible to clarify its duties. At the restitution meeting, the Bank urged the SP/CNLS and the PNLS to find a speedy resolution to the problem in order to have better coordination of control efforts.

2.5.3 At the decentralized level, the different committees that have been set up (CCLS, CALS, CQLS,CCLS) are evidently not operating with any degree of efficacy. They are barely, if at all, functional, the result of a lack of resources and institutional support. Equally noticeable is a lack of appropriation of actions adopted for on-site implementation. Several months after they were drawn up, for instance, the community-based plans prepared during workshops held at the central level, had not been transmitted to the local governments. In its meetings with all the governmental structures, the Bank noted that most State structures do not allocate own resources to HIV/AIDS control activities.

2.5.4 The Bank noted that there was still very low private-sector participation in action against AIDS, despite the existence of the HIV/AIDS Benin Foundation established in 1999, and whose members are economic operators. The private sector, as an employer of a section of the active workforce could be an effective partner in the fight against AIDS. It would be beneficial to involve it in fund mobilization, and in the strategy for prevention and medical care of PLWHIV.

2.5.5. An important indicator for measuring the impact of anti-HIV/AIDS activities is sero-prevalence. The resources allocated to the PNLS for epidemiological surveillance are mainly from the State and are therefore inadequate. The Bank noted the urgent need to reform the present surveillance system. This will require expanding the sentinel network, intensifying advocacy to bring down the cost of reagents and consumables, and training staff to use second generation surveillance methods. Government must work together with the partners to establish the conditions that will ensure sustainability of the surveillance system.

2.5.6 In discussions with the other players working to control AIDS, the Bank noted a risk posed by the challenge of ensuring optimal utilization of resources. Thus, even though, clearly, additional resources could still be mobilized, every effort must be made to ensure optimal management so as to guard against the resources being allocated to sectors like water and sanitation which come next to AIDS on governments' and donors' priority lists. The political will to intensify action against AIDS must therefore be unswerving.

Local response

2.5.7 The Bank noted with regard to the local response that for decentralization to be achieved as desired, stakeholders at every level must be massively involved. Training for the heads of the decentralized structures if therefore crucial. Similarly, for the activities on the ground to be sustainable, people who are trained must be there permanently. The Bank's finding, to the contrary, was that those on the communal committees are not permanent members. In addition, there is a lack of motivation and hardly any form of voluntary work, if at all. Stakeholders on the ground must contemplate ways to motivate the human resources they need wage the war against AIDS.

2.5.8 In order to be more in tune with the beneficiaries, numerous activities will need to be undertaken at the decentralized level (departments, communes, districts, and villages). Awareness and IEC campaigns must therefore be harmonized and coordinated in order for them to have maximum impact in the target populations.

2.5.9 The care of PLWHIV is an important part of AIDS control. The cost of medical treatment is very high in Benin. The Bank's discussions with different players in the field indicated that the molecules could be used more rationally if protocols on standardized treatment were adopted. Furthermore, the costs could be brought down by purchasing generic drugs and centralizing purchases at the sub-regional level.

2.5.10 At the conclusion of the analysis of constraints to HIV/AIDS control, the main areas selected for the project are prevention and traditional medicine, and institutional capacities, which the Bank and the Government consider to be important aspects of the ongoing efforts to combat the AIDS pandemic. Other partners will address the challenges and the other areas that were not selected by the Bank.

3. AREAS OF INTERVENTION

The project's areas of intervention are : (i) prevention of HIV/AIDS, and institutional capacity-building.

3.1 HIV/AIDS prevention and traditional medicine

3.1.1 Prevention of HIV/AIDS depends on accessibility to appropriate information on how to avoid infection or how to improve one's health status by contacting structures that cater for PLWHIV. IEC is vital to make the people understand, and become involved in measures to contain HIV/AIDS. It must be reflective of local specificities and be adapted to the target group. The Government and development partners recognize the importance of IEC/BCC activities in AIDS control, which is why most of their projects and programmes to control AIDS have an inbuilt IEC component (cf Table 2.4. on intervention by donors). Nonetheless, there is no overview of the situation and no documented indicators of its impact. Central and decentralized government structures alike have incorporated awareness-raising and education to prevent AIDS in their action plans, but they are all under-resourced. The objectives of the different coordination institutions prove that Benin is alive to the reality of AIDS and the need to harmonize the message of prevention, and to disseminate that message.

3.1.2 Among its other activities, the PNLS is responsible for sero-surveillance, which is one of the main sources of data for compiling reliable indicators. However, resources for strengthening the sero-surveillance system are limited because only the State and USAID support the system. The subject of epidemiological surveillance in Benin is treated in paragraphs 2.1.1 to 2.1.5 of this document. The need to build capacities for sero-prevalence surveillance to improve its effectiveness depends on whether there is a readiness to provide the PNLS with the human and material resources for its activities.

3.1.3 Voluntary testing is an essential link in the fight against HIV/AIDS. When people know their serological status, they can take necessary steps to improve their health, nutritional and psychological condition. Access to confidential testing services, free of stigmatization, is crucial. In Benin, figures for voluntary testing are rare. There is an anonymous testing centre, the Information and Counselling Centre (CIC) in Cotonou, and in 2001 it recorded 4 981 persons tested (0.7% of the population of Cotonou). The other structures that offer affordable testing are mainly the blood banks and certain religious structures; there are however no figures available. The PNLS, which has primary responsibility for testing services, should coordinate the testing centres and centralize the data to obtain reliable indicators for use by national and international actors in this field.

3.1.4 In Benin 4% of HIV infections occur through vertical transmission from mother to child. According to the global estimates of the PLNS, (2000), 11 500 seropositive women give birth each year. A third of such children are infected. Reducing mother to child transmission is a key objective of the national strategic framework. The Ministry of Heath, in association with UNICEF and French Cooperation, established an operational research project in 1998 known as MTCPP. This pilot project, which covered 33 maternities in the communes of Cotonou and Abomey-Calavi, was based on group counselling for pregnant women on the risks of HIV, then access to free voluntary testing. Women who tested positive and were enrolled in the programme were offered biological check ups, prophylaxis for opportunistic infections, and the cost of reducing transmission through ARV drugs. Their babies were monitored after birth and the women received advice on whether to breastfeed their babies and wean them early, or whether to feed the babies exclusively on artificial milk. A review of the programme, carried out in 2002, revealed a need to upscale it to the national level, after readjustments would have been made in terms of the institutional and regulatory framework, review of the documents, definition of criteria for the selection of sites, the communication strategy, and supply of test kits. The PLNS, as the chief mover of the programme, is gearing up to mobilize resources, and for the extension of MTCPto all the departments. In addition to UNICEF, the French Cooperation and the Global Fund support the programme in clearly-targeted areas.

3.1.5 Traditional medicine, being at the forefront as a primary health provider, is a major player in catering for PLWHIV. However, its role in the psychosocial and medicinal catering for PLWHIV is neither standardized nor documented. Indeed, how to mainstream traditional medicine into the national health care system and introduce a code governing its practice is a major challenge to HIV/AIDS control. This is why PNLS has been campaigning for traditional medicine to be recognized and integrated as a player in efforts to contain the pandemic.

3.2 Institutional Capacities

3.2.1 In Benin, the Government has set up the different structures to coordinate and implement AIDS control activities at both the central and decentralized levels. Details of the institutional framework are given in Chapter 2.2. The PS/CNLS, established two years ago, has been given the senior management staff and the minimum equipment it requires for its triple role of coordinating, supervising AIDS control activities, and mobilizing resources for implementation of the different interventions. However, the human and financial resources available to the PS/CNLS are inadequate, and also, the structure does not as yet centralize the information that will enable it to coordinate these activities effectively. It depends heavily on the PNLS and the other projects for data on current efforts to control the pandemic. In addition, as at March 2004, the State was yet to vote any resources towards the budget of the PS/CNLS.

3.2.2 At the decentralized level, the CDLS, CCLS, CALS and CVLS have been set up but lack of public awareness and inadequate resourcing are hampering their operations. These decentralized structures all have plans to launch the awareness raising activities which must underpin any change of behaviour, and which will prompt people to know their HIV status, and to lessen the stigmatization suffered by PLWHIV. Unfortunately, apart from support from certain partners such as the World Bank through its PPLS project, these AIDS control committees at decentralized level, do not receive financial assistance. Decentralized administrations hardly ever allocate resources for HIV/AIDS control. It is crucial to enhance the capacities of these structures in order to promote increased public awareness of the pandemic in Benin. Moreover, the structures do not always have the skills and competencies they require to carry out their control activities effectively.

4. THE PROJECT

4.1 Design and Rationale

4.1.1 With regard to the project design and rationale, the identification and preparation /appraisal missions were mindful of the objectives set out in the different policy and strategy papers on combating poverty and HIV/AIDS in Benin. The project is technically justified in that its design is consistent with the principal thrusts outlined in the strategic framework of action against HIV/AIDS, the national response paper, the Poverty Reduction Strategy Paper, the Bank policy and strategy on the control of HIV/AIDS, health, population, education and the millennium development goals. The Bank accords great priority to HIV/AIDS control and considers this a flagship project which, if successful, will encourage greater resource allocation to efforts to combat the spread of this pandemic.

4.1.2 The strategic thrusts of the ADF project are in line with 7 of the 11 objectives set out in the strategic framework paper (cf paragraph 2.3.2). Activities planned under the three project components are consistent with the efforts being made to (i) intensify local response by developing activities to effect a change in behaviour (BCC) ; (ii) strengthen the epidemiological surveillance system, measures of preventing transmission of HIV/AIDS and STIs, voluntary testing, development of MTCP activities and traditional medicine, and (iii) support to structures working in the realm of HIV/AIDS control and implementation of actions to combat HIV/AIDS. The conclusions and recommendation from the portfolio review carried out in 2003 and the project completion report of the Health Project II were also taken into account in designing this project.

4.1.3 The project's value added in comparison to interventions by other donors includes the following aspects; (i) the project design has taken into consideration the six communes with highest prevalence rates at Department level; (ii) epidemiological surveillance activities (only USAID is assisting the Government) ; (iii) MTCP, financed partially by French cooperation and UNICEF; testing activities, which have a very low coverage ; traditional medicine, which is funded by none of the development partners ; support to agencies engaged in HIV/AIDS control (the World Bank's PPLS has initiated a few activities within certain committees and the PS/CNLS) and ; strengthening of IEC activities which need to be carried out continuously, in tandem with ongoing efforts to contain the pandemic.

4.1.4 The participatory method was adopted during the identification and preparation/appraisal missions and consisted in working sessions with the Ministry of Finance and Economy, the Ministry of Family Affairs, Social Protection and Solidarity (MFPSS); the Youth, Sport and Leisure Ministry (MJSL), the Ministry of Planning and Development (MCPPD), Ministry of Interior, Security and Decentralization (MISD) and other structures coordinating and implementing activities in the HIV/AIDS control sector. In addition, to ensure greater beneficiary involvement in the project design and implementation, the Bank visited Porto Novo, Comé, Ouidah and Lokossa communes and discussed with administrative heads, service providers in the HIV/AIDS control effort, opinion leaders, the beneficiary communities including affected and infected persons, associations and NGOs. Similarly, the Bank has sought to improve coordination with the other players by meeting with those that are working on other areas of HIV/AIDS control funded by the major donors, and has held bilateral working sessions and a restitution meeting with development partners contributing to the implementation of the strategic framework: World Bank, UNDP, WHO, UNICEF, UNESCO, UNFPA and the German, American Canadian and French cooperation agencies.

4.1.5 The project is in consonance with the policy papers on health, HIV/AIDS, population and education of the Government and the Bank. It reflects the government's objectives as concerns traditional medicine. It will also contribute to the attainment of the millennium development goals by laying emphasis on activities aiming to reduce morbidity and mortality among the general populace, and among women, young people and children in particular. As far as attaining the millennium development goals is concerned, Benin may "potentially" achieve the desired goals of improving maternal health (reducing maternal mortality from 498 in 1996 to 390 in 2015), reducing under-five mortality (infant-child mortality down from 166.5 for every thousand live births to 90 in 2015) and reducing the prevalence of HIV/AIDS. Annex 4 (hereto attached) shows the position as regards the MDG in Benin. The project will finance activities to prevent mother-child transmission. It will also contribute to strengthening structures that coordinate and implement HIV/AIDS activities at both the central and decentralized level.

4.2 Lessons learnt from Similar Projects

4.2.1 Despite a substantial portfolio of activities in Benin, the Bank has only recently ventured into funding HIV /AIDS control in the country (cf Annex 4). The other donors, too, are newcomers to the field, as can be seen from Table 2.4, which shows most of the interventions beginning only in 2004. Other Bank-financed projects, such as the project to strengthen the health system (Santé II) did not include an HIV/AIDS control component. That project started off in January 1995, and concentrated principally on improving health care

coverage by providing several infrastructures and establishing a maintenance unit in Borgou commune. Some trainings and procurements of drugs and equipment were funded by the project. One of the project areas is in the city of Parakou in Borgou commune, where a cottage hospital and a few health centres were built and equipped under the Sante II project. Parakou commune is one of the new project areas of for AIDS prevention support. The fact that it already has functional health facilities will facilitate the treatment of opportunistic diseases to which people infected by the AIDS virus are prone.

4.2.2 The Health II project was finally completed in December 2003 after eight years of implementation (slippage on effectiveness, frequent changes of coordinator, weak performance of PIU staff and construction companies). The government has prepared its completion report, with recommendations highlighting administrative bureaucracy that affected loan effectiveness, problems with the civil works, cumbersome bidding procedures, and the long process for the payment of local companies, frequent changes of PIU staff, weak accounting, late audits, etc. etc. With this project, care has been taken to avoid the problems encountered with the implementation of Sante II project, and the following provisions have been made : (i) procurement of equipment and drugs will be done through the IAPSO and UNIPAC to shorten the procedure; (ii) the project has no civil engineering component and so will not face such problems; (iii) the management staff will be contract officers and will therefore be less mobile; (iv) the Bank will ensure regular independent audit missions within the prescribed period; (v) there will be more frequent supervision missions, and ; (vi) the project will have a manual of procedures to enable better implementation of its activities. The government is undertaking a reform of its tender procedures. This should improve and expedite procurement of goods, works and services in the country, and in the specific case of projects in particular.

4.2.3 Since the year 2000, because of the magnitude of the AIDS pandemic in Benin, most social, agricultural and road projects in the country have included a component on HIV/AIDS prevention. In the social sector, for example, the Education IV project, which started up in February 2004, includes a component on STI /HIV/AIDS and malaria awareness in schools and in all the training and advanced training programmes offered locally.

4.2.4 In the agriculture sector, the Projet bois de feu (Phase II) (Fuelwood Project), begun recently in March 2002, will finance the production and dissemination of leaflets on issues such as STI and HIV/AIDS prevention, health, hygiene etc. There is a nexus between that and this current project since the enlightenment activities under the latter will buttress similar activities under the agricultural project in certain areas where the two projects overlap. The fuel-wood project will produce simple leaflets in the national languages for distribution annually in 300 villages. Similarly, in the Support Project for the Development of the Mono and Couffo, and the training programme at the four training centres includes HIV/AIDS. The principal beneficiaries of the training provided by these centres are farmers in the project areas, some of whom are young people and women.

4.2.5 In the transport sector, the Djogou-Ndali highway rehabilitation project (Borgou and Donga Departments), approved in December 2003, and not yet effective, finances HIV/AIDS awareness campaigns among the population and for workers on the construction sites. These activities will synergize with IEC activities that are to be developed as part of the HIV/AIDS control support project.

4.3 Project Areas and Beneficiaries

Project areas

4.3.1. The project covers the whole country as concerns providing institutional support to the permanent secretariat of the National HIV/AIDS Control Committee, support to the PNLS in the area of epidemiological surveys and traditional medicine, and financing of impact studies. Other activities, including more specific action, IEC activities, enlightenment campaign for 30 480 pregnant women attending the six maternities selected by the project for voluntary testing of 65% of them (18 288), prevention of mother- child transmission for 912 parturients and their babies, and voluntary testing of 106 510 persons, will be carried out at Savalou, Porto Novo, Comé, Parakou, Natitingou et Ouidah communes, which contain 358 villages.

4.3.2. The choice of the 6 communes was based on the following criteria : (i) the high prevalence rate (the national prevalence rate is 1.9% whereas the target communes have the following prevalence rates : Parakou : 6.4% ; Comé : 5.2% ; Ouidah : 4.3% ; Porto-Novo : 2.7%; Natitingou : 2.9% and Savalou : 1.8%) ; (ii) low representation of development partners ; (iii) they are representative of the different departments (one commune in each former department); (iv) the inland location of some areas, and (v) the location of some of the communes along the Abidjan-Lagos Corridor where there is a heavy movement of people and transporters. The principal economic activities in these communes are: agriculture, hunting and fishing; manufacturing; building companies and public works; trading, restauration and hotel management; transport and communication and other services. The principal activities in Comé, Porto Novo and Ouidah are trading-food service-hotel management, while agriculture, fishing and hunting are the main activities in Savalou and Natitingou. Industrial manufacturing is the main activity in Parakou. Savalou and Natitingou are rural areas (less than 68% of the population), unlike the other commune which are more urban. The Bank's intervention completes those of other partners who already finance HIV/AIDS control activities in other areas of the country. The World Bank is financing a Multisectoral HIV/AIDS Control project) which, despite having national scope, still falls short of requirements in the sector.

Project Beneficiaries

4.3.3 The principal beneficiaries of the project activities are : (i) the populations of Porto-Novo (223 552 inhabitants) in Ouémé-Plateau province, Ouidah (97 932 inhabitants) in the Atlantique-Littoral province; Comé (58 396 inhabitants) in Mono-Couffo province, Savalou (104 749 inhabitants) in Zou-Collines province ; Parakou (149 819 inhabitants) in Borgou-Alibori province, and Natitingou (75 620 inhabitants) in Atacora-Donga province, a total population of 710 068 inhabitants ; (ii) the PSP/CNLS whose capacities will be strengthened and which will then be better able to serve the population of the entire country; (iii) pregnant women (30 480) who will enjoy counselling, awareness sessions, and testing for 65% of them, while 912 seropositive persons will benefit from activities to reduce mother–child transmission; (iv) around 106 510 persons who will undergo voluntary testing ; (v) traditional medical practitioners numbering about 7 500 and their ' target public' and ; (vi) the members of certain NGOs and CBOs. In total, about 884 558 persons will benefit directly from the project activities, representing 13 % of Benin's total population of 6 769 914 inhabitants.

4.4 Strategic context

4.4.1 Project preparation/appraisal took place in a context where a certain number of policy/strategy papers had already been elaborated and certain actions taken to fight HIV/AIDS in the country, namely: (i) the poverty reduction strategy paper which has HIV/AIDS control as one of the government objectives; (ii) the strategic framework for action against HIV/AIDS which sets out the objectives and priority areas of the HIV/AIDS control effort ; (iii) the analysis of the HIV/AIDS situation in Benin; (iv) the response to the epidemic at national and decentralized levels within the target groups; (v) the establishment of a national HIV/AIDS Control Committee with its own permanent secretariat and ; (vi) fluctuation in the prevalence rate which rises and dips but remains constantly high at 4.1%, 3.6% and 1.9% depending on the study.

4.4.2 The project will contribute to lowering the prevalence and incidence of HIV/AIDS and to attaining the millennium development goals, which Benin currently is still short of achieving. The project will promote coordination and monitoring-evaluation of AIDS control activities and encourage the growth of a partnership with the decentralized services, civil society and the UNDP which will all be involved in its implementation. By financing prevention of mother-child transmission, the project will also contribute to improve maternal and child health.

4.5 Project objectives

The project's sector goal is to contribute to reducing the prevalence of HIV/AIDS. The specific objective is to buttress preventive activities, traditional medicine, and the structures undertaking action against HIV/AIDS/STI.

4.6 Project Description

4.6.1 Attainment of the project objectives will be pursued through the following three components :

I Support to preventive activities (epidemiological surveillance, IEC, PRETRAME and testing) and traditional medicine
II Support to the structures working to control HIV/AIDS/STI
III. Project management

4.6.2 The categories of expenditure under the project are the following : A - Services ; B - Goods; C – Operational expenses.

Detailed description of project activities

Component I : Support to preventive activities (Epidemiological surveys, IEC, MTCP and testing) and traditional medicine

4.6.3 The aim under this component is to strengthen preventive activities and traditional medicine and thus obtain a better understanding of the pandemic and also, to contribute to reducing the virus transmission rate among the population in general, and within the target groups in particular. Activities planned under this component are information, education and

communication sessions by NGOs, CBOs and associations through the media, epidemiological surveys, testings, PRETRAME, and traditional medicine. The content of each activity is detailed below:

IEC activities scheduled for implementation by NGOs, CBOs, and associations

4.6.4 In order to educate and better organize the population in the war against HIV/AIDS/STI, the project will finance the cost of services rendered by the CBOs and NGOs which will be recruited to carry out prevention activities and IEC in the 6 communes, 46 districts and 358 areas and villages. These measures will be in addition to those by the committees at the decentralized level, which are included in Component II.

Epidemiological Surveillance

4.6.5 With a view to improving the indicators on the HIV/AIDS situation, the project will finance the strengthening of the epidemiological surveillance system which aims to ensure reliable data on the results and follow-up on behavioural changes among the public. This will entail supporting the supervision of the sentinel network, undertaking annual sero-surveillance surveys on the target groups, and carrying out second generation surveys to monitor behavioral changes. Also, to improve the performance of the personnel in situ, the project will support one training a year for 120 health officers on how to conduct second generation technical behavioural surveys. In addition, the project will seek to improve the quality of data input and analysis by financing the procurement of equipment for a computer workstation (1 computer, 1 printer, 1 UPS) for the PNLS (4 sets).

Testing

4.6.6 To increase the testing rate in the target communes (15%), the project will finance mobile testing by the existing structures by funding for the purchase of reagents for the voluntary testing of 15% of the population in the 6 communes, a total of 106 510 persons. Assuming that 5% of these test positive, that would mean 5 325 persons who will need to be re-tested. The project will pay for the purchase of 106510 quick test kits for voluntary testing and for the confirmation test. The project will provide logistical support to 2 testing sites per commune for the voluntary testing. One of these will be a mobile testing centre, and will involve two persons per testing session every week for the 3-year lifespan of the project. The PNLS will be equipped with two mounted cars -podium for use in the voluntary testing campaign and to disseminate messages urging AIDS prevention. The project will also finance the supply of reagents and consumables for serology. It will also assist with testing activities by the agencies in the surrounding communes and which are used by some of the communities in the communes targeted by the project. (example: St. Camille dispensary at Davougon, and the project being supported by Médecins sans Frontières at Dogbo-Téta, which the Bank visited).

MTCP

4.6.7 As part of the effort to reduce vertical mother-child AIDS transmission , the project will provide support to the implementation of MTCP activities to prevent mother-child transmission in 6 maternities (1 in each commune). These will be in the hospitals located at Comé, Natitingou, Ouidah, Savalou, and community centres at Zongo (Parakou) and Zebou (Porto-Novo). Over a three-year period, the project will provide these 6

maternities with support in the areas of supervision and monitoring - evaluation. Funds from the project will be used to finance the biological assessment, the treatment of opportunistic diseases (Ois drugs), and to reduce mother-child transmission of HIV (by taking ARV : AZT/neverapin) in 912 patients in the 6 target communes. Also, the project will pay for training in patient monitoring and evaluation for the medical staff and heads of the sentinel sites (10 persons per site, for an annual session, 50 staff in all, for the 5 target areas), and for 5-day refresher courses on MTCP for 15 doctors. It will also support train-the-trainers activities at communal level. This will involve five-day training on MTCP for 5 doctors and 4 sociologists or social workers (already working within the health structures or other social services in the 6 communes. For the procurement of goods and services for MTCP and the other activities mentioned above, the project will pay administrative costs of about 5% to UNIPAC and IAPSO (two procurement units within the United Nations system) for the ARV drugs/reagents and for other equipment (vehicles, computer and IEC equipment respectively. The project will also pay for the services of the UNDP for support and advice to the PMU in the execution of decentralized activities. Support will be in the form of missions, conducted jointly with PS/CNLS and the PMU, to monitor and supervise the project activities in the beneficiary districts. UNDP is not charging a fee for its support and advisory role, but the project will pay for the field trips.

Traditional medicine

4.6.8 Given the crucial role that traditional medicine plays in the treatment of PLWHIV, project funds will be committed to financing activities designed to enable traditional doctors to play their roles more fully in HIV/AIDS control. It will thus provide support towards the preparation and validation of a protocol based on proven traditional healing practices that 7 500 traditional practitioners have found to be effective in the treatment of opportunistic diseases. It will, in addition, finance training for 600 traditional doctors (some 10% of the total number) in the areas of harmonization of prevention, diagnosis, treatment of opportunistic infections, and psycho-social monitoring of PLWHIV.

Component II : Support for structures engaged in HIV/AIDS/IST control

4.6.9 The aim under this component is to improve the institutional framework for action against HIV/AIDS by supporting the existing structures by funding trainings, study trips and equipments (equipment limited to 6 communes, their 6 youth and six promotion centres, and PS/CNLS) for structures like NGOs/CBOs, Associations, the six departmental committees (where the 6 six communes targeted by the project are located), the six communes (Ouidah, Comé, Porto-Novo, Parakou, Savalou et Natitingou), the 46 district committees and 358 area or village committees, and the PS/CNLS. The project will also finance activities that are national in character (impact studies, trainings, production of documentaries etc.).

NGOs, CBOs and associations

4.6.10 The project will pay for the services of consultants (the same consultants who will be recruited to assist the SP/CNLS) who will help to improve the care of PLWHIV, with support from associations of PLWHIV. They will help to boost the intervention capacities of grassroots associations and NGOs carrying out decentralized activities. The project will also support IEC sessions for youth and socio-professional associations, and civil society. (3 groups of 150 persons each, and 3 one-day sessions per year). Project funds will also go towards study trips for trainers of CBOs and those of NGOs. These study trips will enable

them to swap experiences at regional level. Anyone who benefits from these study trips as part of the project must prepare a report on their return, to be sent to the PMU, which will disseminate the information through the appropriate structures.

Communal, district and village level

4.6.11 Within the communal HIV/AIDS control committees, the project will finance training sessions in monitoring and evaluation, microplanning and IEC (5 sessions for 4 persons/commune for 4 days). The project will fund IEC sessions, chat-discussion sessions in the 358 areas and villages of the 6 target communes so as to ensure that the enlightenment campaigns reach the entire population at every level. To strengthen decentralization, the project will support training sessions on identical themes in the 46 districts, 189 areas and 169 villages within the 6 communes. Project funds will also be put towards training in IEC for 16 women and 24 men from each commune, leaders of men and women's cooperatives respectively. In all, 96 women and 114 men will undergo 2 days of training in 2005. These men and women will relay the message of awareness to the population. In addition, the 6 community based committees, and their youth social promotion and youth centres, will be provided with computer, audiovisual and IEC equipment for their training and IEC activities. Partnership agreements between the communes and six rural or proximate radio stations will be funded by the project, to boost awareness raising activities among the population.

National level

4.6.12 The project will fund training courses (to be co-coordinated by SP/CNLS), in monitoring-evaluation, microplanning and IEC for staff of the 6 CDLS and 35 UFLS in Ministries, training centres and institutes, the University, and ORTB (Benin Radio) (5 persons per structure, a total of 175 persons for 5 days). This training is for all the key personnel within these structures.

4.6.13 The project will support training seminars for all the directors and coordinators of the 575 projects and programmes under the public investment programme, to heighten their awareness of the importance of the battle against the pandemic and the need to include HIV/AIDS control activities in development projects. The PMU and the Ministry of Planning and Development will coordinate implementation of this activity.

4.6.14 The project will finance two HIV/AIDS impact studies in the country, one on teachers (26 staff/month) and one on the agriculture sector (25staff/month). The results will show the impact of the pandemic in the two key areas of education and agriculture. The study conclusions will also provide insight about the loss in terms of human resources, farm output, education, and on the economy in general etc. The two studies will be piloted by the PMU, in collaboration with the Ministry of Planning (MCPPD), which handles population and human resource issues. The project will support the making of a documentary film on HIV/AIDS and STIs as a means of raising awareness in the general public.

PS/CNLS

4.6.15 The project will contribute to enhancing the capacities of the PS/CNLS, the only structure established by the State (in May 2002) to coordinate HIV/AIDS control activities. The PS/CNLS has only just begun the activities assigned to it in the strategic framework for action against HIV/AIDS.

4.6.16 Project funds will provide the PS/CNLS with technical assistance towards monitoring evaluation, microplanning, IEC and community development (9 staff/month). It will thus assist the PS/CNLS to set up an effective national monitoring system. In addition, under the coordination of the PS/CNLS and the PMU, the project will finance a study (4 staff/month) to inventory all NGOs operating in the HIV/AIDS sector. This inventory will clarify the specific activities of all players in the field. Also, familiarity with the work of these NGOs will be useful when it comes to short-listing service providers for decentralized activities.

4.6.17 The project will finance study tours and attendance at regional conferences which will give SP/CNLS officials, and eventually officials of the other structures, exposure to the outside world; this will be a means of expanding their scientific knowledge and their advocacy tools.

4.6.18 The project will support the publication of a bi-monthly news bulletin and the creation of a website with a view to improving communication at the PS/CNLS with others engaged in HIV/AIDS control in Benin. It will also finance the production of 4 000 IEC brochures.

4.6.19 In addition, two annual workshops for 100 participants will be organized with project funds, to enable the SP/CNLS to improve its advocacy with bilateral and multilateral partners. With the support of the project, the SP-CNLS will use local radio stations to broadcast its activities and air its sensitization messages.

4.6.20 The project will provide the PS/CNLS with a 4WD vehicle for its supervision mission, a portable computer for its monitoring- evaluation, and 3 air conditioners, a multimedia room on the control of HIV/AIDS, sets of audiovisual materials (1 television, 1 digital camera, 1 VCR, 1 DVD) and IEC (data-show, flipchart).

Component III : Project Management

4.6.21 A project management unit will be set up inside the premises of the PS/CNLS, which will supervise and coordinate its activities. The project will pay the salaries of five contractual staff: a Project Officer (36 months), a specialist in monitoring-evaluation (36 months), an account manager (36 months), a specialist in IEC/training (36 months) and a specialist in goods and services procurement (24 months), all of whom who will be recruited from short-lists drawn up following a call for applications at the national level. The management unit will have support staff paid by the project, and who will comprise a secretary, two drivers and a gardener/messenger. Short-term consultancy services (18 staff-month), financed by the project, will be recruited by the project management unit on an ad hoc basis. The project will fund the installation of a computerized account management system and three annual audits of the project accounts, as well as an audit at project completion. The project will also pay for an ex-ante study (4 staff-months) and an evaluation a posteriori (4 staff-months) to confirm or complete respectively the indicators for the project areas before and after the Bank's intervention. The project will also finance trainings for staff of the PMU in the areas of procurement of goods and services, and study trips within the sub-region, including the Bank's Temporary Relocation Agency (TRA) in Tunis. The project will also pay for the services of a consultant (4 staff-months) to prepare the project completion report.

4.6.22 The PMU will be provided with equipment [1 official car, one 4WD vehicle, 3 air conditioners, 5 computers and accessories, a fax, a photocopier, a data show etc…] and the necessary furniture to enable it function properly.

4.6.23 The project and the Government will bear the operating expenses of the project: trips, fuel, electricity, telephone, fax, internet, courrier (UA 0.10 million).

4.7. Environmental impact

The project has been classified under environmental category III and an environmental annex will therefore not be necessary as it will have no adverse impact on the environment. Sensitization sessions for service providers at community level will include counselling on the management of condoms used by the population, the destruction of reagents used for testing, and decontamination of samples. Solid wastes generated during the testings will be incinerated in the health structures which will be equipped with incinerators. All soiled objects will be decontaminated using the appropriate materials and products.

4.8 Cost

4.8.1 The total cost of the project, net of taxes and customs duties, is estimated at UA 2.84 million: UA 1.40 million is in foreign exchange (appr. 49% of total cost), and UA1.44 million in local currency (51% of the total project cost). Provisions of 4% for contingencies and 3% per cent for price escalation have been factored into the project costs. Information on costs was sourced from the Ministry of Finance and Economy, other Ministries such as Health and Planning, and from similar projects financed by other partners. Detailed estimated costs by component and category of expenditure are given in Table 4.1 below:

Table 4.1: Project cost by component

	in million CFA F			in million UA			%
COMPONENT	F.E.	L.C.	Total	F.E.	L.C.	Total	*F.C*
I. Preventive activities/ Traditional medicine	547.81	390,20	938,01	0.69	0.49	1.18	*58%*
II. Support for structures involved in HIV/AIDS control	238.05	555,12	793,17	0.30	0.70	1.00	*30%*
II. Project management	250.81	128.24	379.05	0.32	0.16	0.48	*66%*
Total base cost	1,036.67	1,073.55	2,110.23	1.30	1.35	2.66	*49%*
Contingencies	*41.47*	*42.94*	*84.41*	*0.05*	0.05	*0.11*	*49%*
Inflation	*31.10*	*32.21*	*63.31*	*0.04*	0.04	*0.08*	*49%*
Total cost	1,109.24	1,148.70	2,257.94	1.40	1.44	2.84	*49%*

4.8.2 Table 4.2 hereunder shows the distribution of the total project cost by category of expenditure

Table 4.2: Project cost by category of expenditure

CATEGORY of EXPENDITURE	in million CFA F			in million U.A.			%
	F.E.	L.C.	Total	F.E.	L.C,	Total	*F.E.*
Goods	686 86	0,00	686,86	0.86	0.00	0.86	*100%*
Services	349 81	999 64	1.349,45	0.44	1.26	1.70	*26%*
Operating expenses	0.00	73,91	73,91	0.00	0.09	0.09	*0%*
Total base cost	1.036,67	1.073,55	2.110,23	1.30	1.35	2.66	*49%*
Contingencies	*41,47*	*42,94*	*84,41*	*0.05*	*0.05*	*0.11*	*49%*
Inflation	*31,10*	*32,21*	*63,31*	*0.04*	*0.04*	*0.08*	*49%*
Total	1 109 24	1 148 70	2 257 94	1.40	1.44	2.84	*49%*

4.8.3 Estimated costs by component and by category of expenditure will be set out in the manual of procedures.

4.9 Sources of finance and expenditure schedule

4.9.1 The project will be co-financed by the ADF Grant and the Government as shown in tables 4.3, 4.4 et 4.5 below.

Table 4.3: Project cost by Source of Finance

Sources	In million CFA F			in million U.A.			%	%
	F.E.	L.C	Total	F.E.	L.C.	Total	*F.E.*	*Total*
ADF (Grant)	1,109.24	1,035.81	2,145.05	1.40	1.30	2.70	*52%*	*95%*
Government	0.00	112.90	112.90	0.00	0.14	0.14	*0%*	*5%*
Total cost	1,109.24	1,148.70	2,257.94	1.40	1.44	2.84	*49%*	*100%*
% Total	*49%*	*51%*	*100%*	*49%*	*51%*	*100%*	-	-

Table 4.4: Project cost by source of finance and by component

COMPONENTS	in million CFA F			in million U.A.			%
	ADF	Gov.	Total	ADF	Gov.	Total	*Total*
I. Preventive activities / Traditional medicine	970.53	33.14	1,003.67	1.22	0.04	1.26	*44%*
II. Support for agencies involved in HIV/AIDS control	798.01	50.68	848.69	1.00	0.06	1.07	*38%*
III. Project management	376.51	29.07	405.59	0.47	0.04	0.51	*18%*
Total cost	2,145.05	112.90	2,257.94	2.70	0.14	2.84	*100%*

Table 4.5: Project cost by source of finance and by category of expenditure

CATEGORY of EXPENDITURE	in million CFA F			in million U.A.			%
	ADF	Gov.	Total	ADF	Gov.	Total	*Total*
Goods	734.94	0.00	734.94	0.93	0.00	0.93	*33%*
Services	1, 360.09	83.82	1,443.91	1.71	0.10	1.82	*64%*
Operating expenses	50.01	29.07	79.09	0.06	0,04	0.10	*4%*
Total cost	2, 145.05	112.90	2, 257.94	2.70	0.14	2.84	*100%*

4.9.2 The ADF grant in the amount of UA 2.70 million represents 95% of the total project cost. It covers 100% of the foreign exchange costs (UA1.40 million) and 90% of the local currency component (UA1.30 million). The use of the grant for this project is in line with ADF IX guidelines. The project resources will be put towards activities to enhance capacities for combating HIV/AIDS. The Government will pay for around 10% of the entire project cost in local currency, corresponding to an amount of UA 0.14 million, representing 5% of the total project cost. The Government's contribution will be used to finance about 40% of the operating expenses (UA 0.04 million) and 5% of the cost of services (UA0.10 million).

5. PROJECT IMPLEMENTATION

5.1. Executing Agency

5.1.1 The Ministry for Planning and Development, which coordinates actions by the Government and is the First Deputy Chair of the CNLS, will be the supervisory ministry of the Project Management Unit (cf chart showing organizational structure in Annex 5). The unit will be located in the PS/CNLS premises. The project will recruit four contractual staff: a Project Officer (36 months), who shall be a physician or a health economist with at least five years' project management experience, a monitoring-evaluation expert (36 months), a procurement specialist (24 months), and a training expert (36 months). A summary of the terms of reference of the management staff is given in Annex 9. The detailed TOR will be set out in the manual of procedures.

5.1.2 Staff recruitment will be on the basis of shortlists of candidates drawn up after a general invitation of applications in the country. Recruitment will be justified on the following grounds: (i) the State lacks adequate human resources; (ii) staff are being deployed from the recently-concluded Bank-financed project to improve the health care system (Sante II) ; (iii) capacity constraints in the newly established structures. The management unit shall have support staff comprising a secretary, two drivers, and a gardener/messenger. The PMU shall be the executing agency for ADF.

5.1.3 The PMU shall be assisted by the PS/CNLS, which will supervise and coordinate activities under all HIV/AIDS control projects, including this one. In addition, the PS/CNLS will initially recruit the Project Officer (36 months); it will then assist the Project Officer to recruit the other officers for the PMU: the monitoring-evaluation specialist, the training/IEC expert, the procurement expert (24 months) and the account manager (36 months), before the first disbursement of ADF funds.

5.1.4 The PMU will also be assisted by a steering committee which will be set up to comprise representatives of the structures involved in project implementation, as well as the technical partners. Members will be drawn from: SP/CNLS (2), PNLS (01), PMU (01), MCPPD (01), UNDP (01), one (01) representative of NGOs, the beneficiary communes, i.e. Savalou (01), Porto Novo (01), Ouidah (01), Comé (01), Natitingou (01) and Parakou (01). Each structure will appoint its own representative and notify SP/CNLS accordingly. The NGOs to be recruited under the project, shall designate their representative on the steering committee. The steering committee proposed for this project will meet once every quarter to review progress, and to discuss constraints and propose remedial measures. The need for a

steering committee is justified by the fact that the existing committees, such as the national coordination committee of the Global Fund, coordinate those aspects that have country-wide scope, and are made up of several members (46). Besides, their members are not always directly involved in the project management.

5.1.5 The Government has promised to draw up a manual of administrative and financial procedures that will be modeled on existing manuals being used in the area of HIV/AIDS control (manual for the World Bank-funded PPLS project, UNDP Manual used for management of its support project for the communes), which it will send to the Bank no later than three months from the date of first disbursement of ADF Funds. The draft of the manual shall be approved by the Bank.

5.2. Organization and management

5.2.1 Project management will be carried out by a project management unit. A steering committee, referred to in paragraph 5.1.1, will be set up to guide the project management unit in the implementation and monitoring of project activities. Each of the structures selected will be given training in microplanning to enable it elaborate its action plan, with assistance from the PMU. These plans will then be validated by the PMU and PS/CNLS. The project will also use the services of the different PS/CNLS departments, and will benefit from the services of UNIPAC and IAPSO (Inter-Agency Procurement Services Office) for the procurement of drugs, including ARVs (AZT and neverapin)/reagents/consumables and equipment (vehicles, audiovisual and computer equipment). These structures have vast experience in the area and are able to obtain goods at competitive prices because they make grouped bulk purchases. Similarly, UNDP will be called upon to provide support-advice for activities in the communes. UNDP has been chosen because of its experience with similar projects at the decentralized level. Moreover, the choice of the United Nations central procurement agency was necessitated by the dearth of government functionaries and the weak capacity of the structure in charge of goods and services procurement at State level; and also because civil servants seconded to projects tend to be changed frequently, and are often subjected to pressure.

5.2.2 With specific regard to Component I, PNLS, in collaboration with the PMU and PS/CNLS, will have main responsibility for IEC activities, epidemiological surveillance, and prevention of mother-child transmission, voluntary testing and traditional medicine; these will be incorporated in its current action plan. Working with the PMU and PS/CNLS, the HIV/AIDS control committees will coordinate community-based and IEC activities by NGOs, CBOs and associations of people living with HIV/AIDS (PLWHIV) in their respective areas. Project management at central and decentralized level shall be spelt out in the manual of procedures to be prepared by the Government.

5.2.3 With regard to Component II, the principal beneficiary structures: PS/CNLS and the communal committees, supported by the PMU, will prepare their annual action plans which the PMU and PS/CNLS will consider and validate. Support activities to the departmental committees will be incorporated in the PS/CNLS plan while those for the districts, CBOs and NGOs will be included in the communal plans. These plans will be implemented in conjunction with the PMU and PS/CNLS. The beneficiary populations will participate in the project activities, through their different committees.

5.3. Implementation and Expenditure Schedules

Table 5.1: Implementation Schedule

Activity	Final deadline	By
Board presentation	June 2004	ADF
Signature of Protocol Agreement	July 2004	ADF / Government
Effectiveness	January 2005	ADF / Government
I. SUPPORT TO PREVENTIVE ACTIVITIES AND TRADITIONAL MEDICINE		
Selection of CBOs, Associations and NGOs	January to March 2005	ADF / Government / PS-CNLS / PNLS
IEC activities by the CBOs, Associations and NGOs	July 2005 to December 2007	ADF / Gov. / PS-CNLS / PNLS / NGO and CBO
Strengthening of sero-surveillance (PNLS)	January 2005 to December 2007	ADF / Gov. / PS-CNLS / PNLS
Voluntary testing exercise	January 2005 to December 2007	ADF / Gov. / PS-CNLS / PNLS / NGO et CBO
Implementation of PRETRAME in 6 maternities	January 2005 to December 2007	ADF / Gov. / PS-CNLS / PNLS
Training of 600 traditional doctors	January 2005 to December 2005	ADF / Government / PS-CNLS / PNLS / PMU
II. SUPPORT TO STRUCTURES INVOLVED HIV/AIDS /STI CONTROL		
Strengthening of CBOs, Associations and NGOs	January 2005 to December 2007	ADF / Government / PS-CNLS / PMU / Consultants
Institutional strengthening in 6 communes	January 2005 to December 2007	ADF / Government / PS-CNLS / PMU / NGO and CBO
Training / decentralized structures (micro-planning, monitoring-evaluation and IEC)	January 2005 to December 2007	ADF/ Government / PS-CNLS / PMU / NGO and CBO
Training for the CCLS, CALS et CVLS (micro-planning, monitoring-evaluation and IEC)	January 2005 to December 2007	ADF / Government / PS-CNLS / PMU / NGO and CBO
Implementation of IEC activities (including chats/discussions)	January 2005 to December 2007	ADF / Gov./ PS-CNLS / PNLS / NGO and CBO
Implementation of the different studies	February to June 2005	PS-CNLS / PMU / Consultants
Production of a documentary on HIV/AIDS	March to June 2005	PS-CNLS / PNLS / PMU / Consultants
Training of directors and coordinators of 575 development projects	June 2005 to June 2007	ADF / Government / PS-CNLS / PMU / Consultants
Institutional capacity building SP/CNLS	January 2005 to December 2007	ADF / Government / PMU / Consultants
III. PROJECT MANAGEMENT		
Recruitment of consultants for the PMU	July to December 2004	Government / PS-CNLS
Staff assumption of office, approval of detailed beneficiary activity plans	January 2005	ADF / Government
Implementation of activities contained in the plans	January 2005 to December 2007	ADF / Gov./ PS-CNLS / UNDP / PNLS / NGO et CBO
Procurement of furniture, equipment and official vehicles /PMU	January to February 2005	Government /PS-CNLS / Suppliers
Preparation of drugs, reagents, etc. / UNIPAC	February 2005 to February 2007	Government / PS-CNLS
Preparation of lists of sundry vehicles and equipments / IAPSO	February 2005	Government / PS-CNLS
Delivery and distribution of drugs, reagents, etc. / UNIPAC	April 2005 to December 2007	Government / UNDP
Delivery and installation of furniture and sundry equipment/IAPSO	April to September 2005	Government / UNDP
Monitoring and supervision of project activities (2ce / year)	July 2005 to January 2008	ADF / Gov./ PS-CNLS /UNDP / PNLS / NGO and CBO
Preparation of quarterly project implementation reports	March 2005 to December 2007	ADF / Government
Annual audit of project accounts	January 2006 to January 2008	ADF / Government
Elaboration of PCR by the Government	January to February 2008	Government
Preparation of PCR by the Bank	March to April 2008	ADF

All expenditures will be effected in accordance with the detailed implementation schedule indicated in Annex 6; in accordance with the list of goods and services indicated in Annex 7; the summary of costs indicated in Annex 8 and the expenditure schedule by

component, by category of expenditure and by source of finance is given in Tables 5.2, 5.3 and 5.4 below.

Table 5.2: Expenditure schedule by component

COMPONENT	in million U.A.				%
	2005	2006	2007	Total	*Total*
I. Preventive activities / Traditional medicine	0.50	0.38	0.38	1.26	*44%*
II. Support to structures involved in HIV/AIDS control	0.58	0.24	0.24	1.07	*38%*
III. Project management	0.22	0.13	0.16	0.51	*18%*
Total cost	1.31	0.75	0.78	2.84	*100%*
% Total	*46%*	*27%*	*27%*	*100%*	-

Table 5.3: Expenditure Schedule by Category

CATEGORY of EXPENDITURE	in million U.A.				%
	2005	2006	2007	Total	*Total*
Goods	0.54	0.19	0.19	0.93	*33%*
Services	0.73	0.53	0.55	1.82	*64%*
Operating expenses	0.03	0.03	0.03	0.10	*4%*
Total project cost	1.31	0.75	0.78	2.84	*100%*
% Total	*46%*	*27%*	*27%*	*100%*	-

Tableau 5.4: Expenditure Schedule by Source of Finance

COMPONENT	in million U.A.				%
	2005	2006	2007	Total	*Total*
ADF (Grant)	1.24	0.72	0.74	2.70	*95%*
Government	0.06	0.04	0.04	0.14	*5%*
Total project cost	1.31	0.75	0.78	2.84	*100%*
% Total	*46%*	*27%*	*27%*	*100%*	-

5.4. Procurement Arrangements

5.4.1. Bidding procedures are summed up in Table 5.5 and the details set out in paragraphs 5.4.2 to 5.4.13. All procurements of goods and services financed by the Fund will be subject to the Rules of Procedure for the procurement of goods and the Rules of Procedure for Use of Consultants, by using the standard bidding documents of the Bank Group.

Table 5.5: Procurement Arrangements

CATEGORY of EXPENDITURE	in million UA						%
	Short-List		Others		Total		Total
Goods	***0.00***	0.00	***(0.93)***	0.93	***(0.93)***	0,93	***32.5%***
Sundry furniture and equipment for the PMU			*(0.03)*	0.03	**(0.03)**	0.03	***1.0%***
Light official vehicle for the PMU			*(0.01)*	0.01	**(0.01)**	0.01	***0.5%***
Air conditioners for the PMU and PS/CNLS, sundry supplies and consumables for the PMU			*(0.01)*	0.01	**(0.01)**	0.01	***0.4%***
4WDvehicles for the PMU and PS/CNLS *(via IAPSO)*			*(0.04)*	0.04	**(0.04)**	0.04	***1.4%***
Car podiums for PNLS *(via IAPSO)*			*(0.05)*	0.05	**(0.05)**	0.05	***1.9%***
Computer equipment *(via IAPSO)*			*(0.09)*	0.09	**(0.09)**	0.09	***3.2%***
Audiovisual equipment for the IEC and training courses*(via IAPSO)*			*(0.12)*	0.12	**(0.12)**	0.12	***4.1%***
Drugs, reagents and various consumables *(via IAPSO)*			*(0.57)*	0.57	**(0,57)**	0.57	***2.1%***
Services	***(0.73)***	0.78	***(0.98)***	1.03	***(1.71)***	1.82	***63.9%***
Studies / surveys	*(0.05)*	0.05			**(0.05)**	0.05	***1.8%***
Study trips within the sub-region / international conferences			*(0.07)*	0.07	**(0.07)**	0.07	***2.5%***
Local training, workshops, seminars, exchanges, etc.			*(0.27)*	0.27	**0.27**	0.27	***9.5%***
IEC/BCC activities by the CCLS, CALS et CVLS			*(0.49)*	0.53	**(0.49)**	0.53	***18.7%***
Production of a film and partnership with radios in the vicinity			*(0.06)*	0.07	**(0.06)**	0.07	***2.5%***
Supervision / monitoring evaluation			*(0.03)*	0.03	**(0.03)**	0.03	***1.1%***
Support counselling and monitoring and evaluation missions with UNDP			*(0.02)*	0.02	**(0.02)**	0.02	***0.6%***
Administrative costs / UNIPAC (procurements of drugs, reagents, etc.)			*(0.03)*	0.03	**(0.03)**	0.03	***1.0%***
Administrative costs, / IAPSO (procurement of equipment and vehicles)			*(0.01)*	0.01	**(0.01)**	0.01	***0.5%***
Activities to be implemented by NGOs (trainings, promotion of testing, community-based activities)	*(0.48)*	0.53			**(0.48)**	0.53	***18.8%***
Consultancy services (including Project Officer, monitoring evaluation specialist, accountant, training/IEC specialist and the procurement expert at the PMU)	*(0,14)*	0.14			**(0.14)**	0.14	***5.0%***
Accounting system and audit of project accounts	*(0.06)*	0.06			**(0.06)**	0.06	***2.0%***
Operating expenses	***(0.00)***	000	***(0.06)***	0.10	***(0.06)***	0.10	***3.5%***
Monthly allowances (secretary, drivers and gardener)			*(0.03)*	0.03	**(.,03)**	0.03	***1.0%***
Miscellaneous (perdiem, fuel, electricity, telephone, fax, internet, courrier, etc.)			*(0.04)*	0.07	**(.,04)**	0.07	***2.5%***
Total project cost	***(0.73)***	0.78	***(1.97)***	2.06	***(2.70)***	2.84	***100.0%***

Note bene : the 2nd, 3rd, and 4th amounts under the column "Others" relates to procurement of goods and services through local shopping ; the other amounts, with the exception of the operating expenses category, relate to procurements by direct negotiation
( ) : financing effected from Grant funds

Goods (UA 0.93 million)

5.4.2 National Shopping: Procurement of furniture, official vehicles, part of the equipment for the Project Management Unit and the supplies and consumables (UA 0,05 million), will be done through national shopping (NS) since the amounts involved are quite small and the PMU must start operating immediately. There are enough national suppliers and representatives of foreign suppliers in the country to foster competition and obtain competitive prices. Furnishings and equipment for the PMU (UA 0.05 million) may be divided into a maximum of 7 lots as follows: Lot 1 – office furniture (UA6 736) ; Lot 2 – computer equipment/5 computers and accessories 0 100s (UA 9 440) ; Lot 3 – office equipment/1fax, 2 photocopiers,1 data show and sundries (UA10 100) ; Lot 3 – official vehicle (UA13 468) ; Lot 4 – Fax, photocopiers and data show (UA 8 488) ; Lot-5 - Television, camera, VCR, DVD (UA2 693) ; Lot 6- air conditioners (UA3 030) ; Lot 7 office supplies and consumables (UA 2 003) which, in the course of project implementation, will be sub-divided into several lots.

5.4.3 Direct negotiation with the United Nations Inter-Agency Procurement Services Office (IAPSO, UNIPAC)

(i) IAPSO will be contacted for the procurement of computer and audio-visual equipment; (ii) the project will also use UNIPAC for the procurement of ARV/drugs (AZT and neverapin), reagents and sundry consumables. IAPSO and UNIPAC have a comparative advantage as regards the procurement of standard goods and achievement of economies of scale. Because these structures make grouped international purchases, they are able to obtain prices that are often more competitive (as much as 40% cheaper). These are items that must be acquired urgently, in the very first year, in order to give the PMU and the AIDS control structures the equipment they need to carry out their tasks effectively. Drugs and reagents, for instance, must be readily available for testings and for prevention of mother-child transmission.

5.4.4 The goods to be acquired are as follows :(i) ARV/drugs, reagents and consumables (UA0.57million) from UNIPAC and ; (ii) 2 4x4 vehicles, 1 for PS/CNLS and for the Project Management Unit (UA0.04 million) and 2 cars podium for PNLS (UA0.05 million), and all other computer equipment (UA0.09 million) and audio-visual equipment (UA0.12 million), from IAPSO.

Services (UA1.82 million)

5.4.5 Short lists :This bidding procedure will be used in respect of the following activities:

Recruitment of individual consultants : (i) consultants recruited on an ad hoc short-term basis for the PMU and SP/CNLS and the five long-term consultants for the project management unit, namely, the project coordinator, the accountant, the specialist in IEC/training (UA 0.14 million); (ii) recruitment of individual consultants for studies/surveys (0.05 million) ;

Recruitment of consulting firms, companies and NGOs : (i) recruitment of NGOs for IEC/activities to promote testing, community-based initiatives, etc. (UA 0.53 million) ; (ii) production of a film and partnership with radio stations in the periphery (UA0.07 million) ; (iii) recruitment of auditing firms for the 4 audits (3 annual audits and 1 at project completion) and installation of an accounting system (UA0.06 million); selection of these firms will be subject to the lowest-bid-for-comparable-services principle.

5.4.6 Direct Negotiation : (i) Overseas training for members of NGOs, CBOs and associations (UA0.05 million) are envisaged at one single training institution in the sub-region; (ii) support-counselling, monitoring/evaluation missions with UNDP in connection with the supervision of activities planned in the six selected communes (UA0.02 million) and which should have no additional cost implication for the project; the choice of the UNDP is on account of its experience in implementing projects at the decentralized level; (iii) study trips in the sub-region, and international conferences (UA0.07 million) ; (iv) IEC/BCC activities by communal HIV/AIDS control committees , district HIV/AIDS control committees, and by village and area HIV/AIDS control committees (UA 0.53 million) ; (v) supervision and monitoring evaluation by SP/CNLS and the PMU (UA0.03 million); (vi) local trainings, workshops/seminars/study trips (UA0.27 million) will the subject of direct negotiation with competent trainers available locally. These trainers will not be paid fees but will receive allowances applied by the Government in similar cases, and deemed acceptable to ADF.

5.4.7 Trainings will be recurrent and the amount per contract shall not exceed 12 140 150 CFAF (UA15 290). They will take place at different levels (national, regional, communal, departmental and village) throughout project implementation. Beneficiaries of trainings shall be the technical staff of the SP/CNLS, the members of the 6 communal committees, the 46 district committees, the 189 area committees, and the 169 village committees.

Operating Expenses (UA 0.10 million)

5.4.8 Procurements necessary for the operation of the project (fuel, office supplies, general expenses, Internet, etc.) will be done through; i) short lists of suppliers for amounts below UA 20 000 and ii) national bidding for contracts above UA 20 000.

General Procurement Notice

5.4.9 The text of the General Procurement Notice(GPN) shall be discussed and adopted at the same time as the negotiations and shall be published in *Development Business* as soon as the grant is approved.

Review Procedures

5.4.10 The following documents shall be submitted to the Bank before they are published: special procurement notice; shortlists and requests for consultants, bidding documents and invitation letters sent to the consultants; bid evaluation report comprising recommendations on the choice of NGO service providers or consultants selected, and draft contracts. Bank missions will undertake an a posteriori review of the different individual consultant contracts for less than 60 days to verify that they are in accordance with Bank Rules.

5.5 Disbursement Arrangements

5.5.1 The Project Coordinator shall, with PS/CNLS support, verify that the services rendered by suppliers and service providers, including UNDP and NGOs, meet the specifications and the disbursement requests by the latter before they are sent to the CAA (sinking fund) for onward transmission to ADF. These requests must be for a minimum amount of UA 20 000 for Grant-funded payments, except in respect of disbursement requests for : (i) services, (ii) contracts that are 100% guaranteed and require one single outright payment, (ii) balance outstanding on a contract, on a category of expenditure, several categories of expenditure combined, or on the grant. The two payment methods are direct payment and special account. Detailed disbursement procedure can be found in the ADF disbursements manual.

5.5.2 Two accounts will be opened: (i) a special account at a commercial bank to receive ADF resources and; (ii) an account in a commercial bank to receive the counterpart funds. The first disbursement shall be made immediately on grant effectiveness and after the conditions precedent to the first disbursement have been met. The account that will receive the grant funds will be constituted after 50% of the previous deposit has been used and the supporting documents have been approved by ADF.

5.6. Monitoring and evaluation

Activity reports

5.6.1 The project coordinator shall transmit to the Bank quarterly activity reports which will be prepared in accordance with Bank format, on the basis of progress reports submitted by the four focal points in the selected ministries, the PNLS, UNDP and any other project partner: the departmental and district committees in the six communes targeted by the project, district and village committees, as well as short-term technical assistants.

Supervision

5.6.2 Supervision will be provided at central and decentralized level. There will be a quarterly supervision by the project team to monitor progress on the project and to help all involved to understand it and find solutions to specific problems hampering its proper implementation. The HIV/AIDS control committees at the decentralized level will monitor project activities at departmental, communal, district and village and area levels. The Bank will also organize periodic supervision missions (at least three missions every other year) which will include all partners involved in the implementation of project activities. Copies of the reports of these missions will be transmitted to the Beninese authorities for action.

Mid-term review

5.6.3 A tripartite mid-term review (Bank/Government/technical partners) will be organized about 18 months into the project. The review will seek, essentially, to assess progress made and determine to what extent the performance, in terms of project implementation, tallies with the project objectives; highlight the strengths and weaknesses, and proffer appropriate solutions, including new orientations if necessary.

Monitoring and evaluation

5.6.4 In implementing the Strategic Framework of action against HIV/AIDS, the monitoring and evaluation service of the PS/CNLS shall monitor and evaluate the different interventions, including those of the present project. It is pertinent to note that since mid March 2004 certain donors have already started to assist the PS/CNLS to elaborate a monitoring evaluation development plan for AIDS control activities that will be validated by September 2004. WHO paid in March 2004 for the services of a consultant in March 2004, to begin preliminary work on developing pertinent monitoring-evaluation indicators. The project will pay for a consultant to work on the application of the monitoring evaluation system within the PS/CNLS. Also, a monitoring-evaluation expert will be recruited under the project, who will be expected to establish a system of monitoring the project activities using the project indicators set out in the logical framework and those stemming from the ex-ante study, as well as the system that will be used within the PS/CNLS. A project appraisal at the beginning and a project completion report at the end of the project are also envisaged for financing under the project. Lastly, the Government and the Bank will prepare project completion reports (PCR) on project completion..

5.7 Financial and Audi t Report

Financial management of the project shall be handled by an accountant. In addition, an accounting system shall be established and a manual of accounting procedures prepared. The project's accounts shall be audited annually with another audit to be conducted at project completion. These shall be undertaken by internationally reputable audit firms. The audit reports shall be prepared immediately at the close of every financial year and forwarded to the Bank within six (6) months thereof. If necessary, disbursement of ADF funds shall be suspended.

5.8. Aid Co-coordination

5.8.1 Aid coordination at country level is the purview of the Directorate of External Contribution to Development, an arm of the Ministry of Planning and Development (MCPPD). The Bank contributes to strengthening coordination in Benin. The poverty reduction strategy support project and the project on good governance were prepared in collaboration with different development partners. In the water sector, for instance, the Bank, in conjunction with the Water and Sanitation Initiative, has established a system of coordination with development partners.

5.8.2 In the case of HIV/AIDS control, the MCPPD is the supervisory Ministry of the PS/CNLS, which coordinates all anti-HIV/AIDS activities. A UNAIDS thematic group has been established and meets regularly to better coordinate the different interventions in the sector, and to offer advice to the Government on how to fight the pandemic. A coordination committee has also been set up and is functional.

5.8.3 The CNLS permanent secretariat is a fledgling structure and is not yet as dynamic as it will have be in the way it carries out its role of coordinating activities to combat HIV/AIDS. The Government, and donors such as the World Bank, through its PPLS Initiative, are helping to boost its performance. The project envisions support in the form of training and equipment for the PS/CNLS and financing to help strengthen it in its coordination role.

5.8.4 For this particular project, coordination of activities with the other donors will be the responsibility of the project officer, who will endeavor to attend meetings with partners and those organized by PS/CNLS, during which she/he will exchange views with the participants on the project activities. The project officer will meet with other projects and partners working in areas that overlap with the present project. Thus, in the area of institutional activities, the project will complete the work already started by PPLS. Its activities to strengthen the surveillance system will complement actions being financed by USAID and the Government. With regard to MTCP, testing and care of PLWHIV, the project will complete ongoing efforts by the Global Fund, French Cooperation and UNICEF.

6. PROJECT SUSTAINIBILITY AND RISKS

6.1. Recurrent Costs

The project will not finance the construction of new infrastructure which would entail recurrent costs (salaries, maintenance costs etc.) It will finance some technical and logistical equipment which will incur annual low recurrent charges of U.A. 21,692 (17.02

million CFA F), which the government can support quite easily. The amount of costs generated by the project represents a mere 0.002% of the budget for HIV/AIDS control in 2004. The project will finance a number of important activities related to capacity-building and sensitization, which will incur no recurrent costs.

6.2. Project Sustainability

6.2.1 Half of the resources for the project will be set aside for funding sustainable institutional activities for the central and decentralized structures already in place, to improve their national response capabilities, and for activities to improve the sero-surveillance system, the MTC Programme, and traditional medicine. At the end of the project, these structures will continue to run normally and permanently, with no recurrent costs except for the maintenance of light equipment acquired under the project.

6.2.2 The train-the-trainers activities, which will provide trainings on an ongoing basis, tend to ensure sustainability of the project outcomes. IEC activities financed under the project will promote behavioural change (through a change in mentality), removing the stigma attached to AIDS, and ensuring the sustainability of the project outcomes. The change in behavior, along with complete beneficiary and stakeholder involvement, will serve to ensure the project outcomes continue beyond the project's lifespan.

6.2.3 In addition, the location of the Project Management Unit within the PS/CNLS team facilitates the transfer of knowledge between the technical assistants and the State officials who will stay on to ensure sustainability of the project benefits. The project recurrent costs are negligible and account for only 0.002% of the amount earmarked in the State's 2004 budget for HIV/AIDS control.

6.3. Principal risks and mitigating measures

6.3.1 The principal project risks are the following: (i) low capacity of the centralized and decentralized structures set up for HIV/AIDS control; (ii) Government and partners no longer prioritize HIV/AIDS control and do not allocate enough resources to it, (iii) the Ministries and decentralized structures do not use the vote earmarked for AIDS control for the purpose, and (iv) there is no beneficiary appropriation of the project activities.

6.3.2 The first risk factor is the limited capacity of the centralized and decentralized structures to tackle HIV/AIDS control. The project and other development partners will finance the recruitment of consultants and trainings in micro-planning, monitoring-evaluation and IEC. Also, the communal and district authorities interviewed during the mission promised to participate in financing HIV/AIDS control, especially as relates to capacity-building for the structures with responsibility for tackling the pandemic.

6.3.3 The second risk is that Government and donor commitment may falter, even though the Beninese authorities and the development partners interviewed during the appraisal mission pledged that they would wage a relentless long-term war against AIDS.

6.3.4 The third risk lies in the fact that the Ministries concerned and the decentralized structures are not pulling their weight in the fight to contain AIDS, because they lack the resources and the motivation to do so. All the stakeholders that we met with stated that they would rise to the battle against AIDS if they were given the necessary means.

6.3.5 The last risk has to do with stakeholder ownership of the project. The project aims to expand voluntary testing, and to contribute to reducing mother-child transmission. This calls for the population to be educated on the need to visit the appropriate structures to be tested, for pregnant women to attend antenatal clinic and to be able to negotiate with their partners and convince them to use condoms. IEC activities and the chats-discussions organized as part of the project activities should make it possible to mitigate the risk that the testing centres and MTCP will not be put to full use, and the risk of infection through unprotected sex.

7. BENEFITS

7.1 Socio-economic impact

7.1.1 The project is helping to reduce the incidence and prevalence of HIV/AIDS. The pandemic is exacting a heavy toll on the country's economy. In 1999, one of the rare studies carried out showed the effect of AIDS on households, businesses and other sectors of the economy. It showed that households make great efforts to cater for members suffering from AIDS. Among a sample group of fourteen employees of one company and their families, 85.3% had lost close relatives and were caring for widows or widowers and the orphans. The disease had had a disastrous effect on welfare in 83.6% of cases in the form of loss of revenue, depression, anxiety, etc. In addition, 75% of the cost of treatment was being borne by the patient, his or her spouse, and the extended family.

7.1.2 With regard to businesses, (the 14 enterprises in the sample group mentioned earlier), 50% of those infected with HIV were management staff, and were thus people in key positions. Employers noted a cumulated absenteeism rate of up to three months in a year. They also cater for the families of their affected staff, increasing their expenditure and reducing their profit margin.

7.1.3 In areas like the health sector, AIDS increases the number of persons requiring medical care, and AIDS treatments cost much more than for other diseases. The Government thus faces the following dilemmas: (i) whether to assume the medical cost of caring for persons infected with AIDS or to prevent infection by HIV; (ii) to care for those suffering from AIDS or treat other diseases; (iii) to spend money on the health sector or on other sectors. The following observations were made in the education sector: (i) the numbers of experienced teachers available have fallen because of AIDS; (ii) children may be withdrawn from school to care for a person suffering from AIDS or to go and work on the farm; (iii) children may drop out of school due to the death of one or both parents.

7.1.4 At the macroeconomic level, AIDS-related deaths lead to a reduction in the available manpower. Most of those who die are young people, who are at their most productive and are thus hard to replace. The resultant fall in government revenue and private savings translates into less accumulation of capital and savings.

7.1.5 Apart from the outcomes already enumerated in the above paragraphs, capacity-building measures will impact on the coordination and coherence of action taken to control HIV/AIDS at the central level, and on the responsibilities assigned to decentralized structures. The competencies of all stakeholders to carry out monitoring-evaluation, microplanning and IEC will be boosted, and this will apply to everyone from CNLS senior cadre to the decentralized committees (CCLS,CALS,CQLS/CVLS), and the service providers

(NGOs and community-based associations) in between. Some 3250 persons will benefit from trainings in different fields and at least 884 558 persons, 13% of the total population of Benin, will benefit directly from the project.

7.1.6 Members of the decentralized structures, i.e. the HIV/AIDS control committees in the departments (6 departments), communes (6), districts (46) and villages (358 areas and villages), will be given the training and the equipment they need to educate the population and monitor closely activities to combat HIV/AIDS. NGOs and CBOs will also receive training and study tours will be organized for them to strengthen their contribution to the local response.

7.1.7 Strengthening the epidemiological surveillance system will help to ensure more reliable indicators, which serve as the yardstick for measuring the results and impacts of the fight against HIV/AIDS. These indicators give the different players a better picture of the results of their efforts, and will also enable them to plan and evaluate their interventions more effectively.

7.1.8 Communication and awareness-raising activities will also usher in a change in people's attitudes towards the pandemic, and this is especially true of the youth, who are a vulnerable group. Testing will enable the populace to know their serological status and encourage them to contact the appropriate structures for treatment. 106 510 people will have access to testing services.

7.2 Gender Impact

7.2.1 Activities to prevent mother–child transmission will reduce the incidence of infection from mothers to babies. This activity will touch about 912 women and their babies in the target communes. By the time it is completed, the project will have helped to lower the rate of mother-child transmission of the virus by 15%.

7.2.2 Through sensitization campaigns, couples will be better able to understand the measures that can be taken to prevent HIV/AIDS and they will also gain more insight into the gender dimensions of HIV/AIDS control. Women can then negotiate better with their partners, on whom they must impress the fact that the risk of contracting HIV/AIDS through unprotected sex is far worse than the risk of breaking up their homes. HIV transmission rate among men in Benin in 1996 was double that of women but is now level in 2004.

7.2.3 Women are subjected to socio- cultural practices like levirate and sororate. They are also socially and economically disadvantaged, and this pushes them into becoming commercial sex workers, with the risk of becoming sero-positive through having unprotected sex with multiple partners. 240 heads of groups and cooperatives (96 of them leaders of women's and 144 leaders of men's cooperatives) will be given training and can then function as teachers within their communities, and convey message of IEC to their peers and their partners in the home.

8. CONCLUSION AND RECOMMENDATIONS

8.1. Conclusion

The project is consistent with the country strategic framework of action against HIV/AIDS, the PRSP, the CSP and the Bank Strategy on HIV/AIDS control. The project will boost IEC activities, reduce mother–child transmission rate by 15%, create awareness among at least 30 480 pregnant women about, care for 912 parturients and their babies, and will increase to 16 510 the number of people that have been tested. In addition, the project will better educate 7 500 traditional doctors about anti HIV/AIDS control and about referring patients to health institutions. It is boosting efforts being made by the structures coordinating and implementing HIV/AIDS control activities at national, village and district levels (358 village or district HIV/AIDS control committees), within districts (6 committees), within communes (6 committees) and within the departments (6 committees).

8.2. Recommendations and conditions

It is recommended that a grant not exceeding UA 2.70 million be granted to the Republic of Benin for the implementation of the project described in the present report. This grant will be subject to the general Bank conditions and to the following specific conditions:

A. Conditions precedent to grant effectiveness

The entry into force of the Grant Protocol will be subject to the donee's compliance with the provisions stipulated in section 4.01 of the General Conditions Applicable to Grant Protocols governing the activities of the Fund, established on 19 June 1991.

B. Conditions precedent to first disbursement

Apart from the conditions precedent to entry into force of the present Grant Protocol, the first disbursement of the grant resources will be subject to fulfilment, by the Donee, of the following conditions:

(i) provide the Fund with evidence that a steering committee has been established, composed of representatives of the SP/CNLS (02), the PNLS (01), MCPPD (01), UNDP (01), a representative (01) representing the NGOs, beneficiary communes, namely Savalou (01), Porto Novo (01), Ouidah (01), Comé (01), Natitingou (01) and Parakou (01), (paragraph 5.1.4);

ii) Provide the Fund with evidence of the opening of two bank accounts; (i) a special account with a commercial bank, into which the ADF resources will be paid; and (ii) an account with a commercial bank into which the national counterpart funds will be paid (paragraph 5.5.2);

C Other conditions

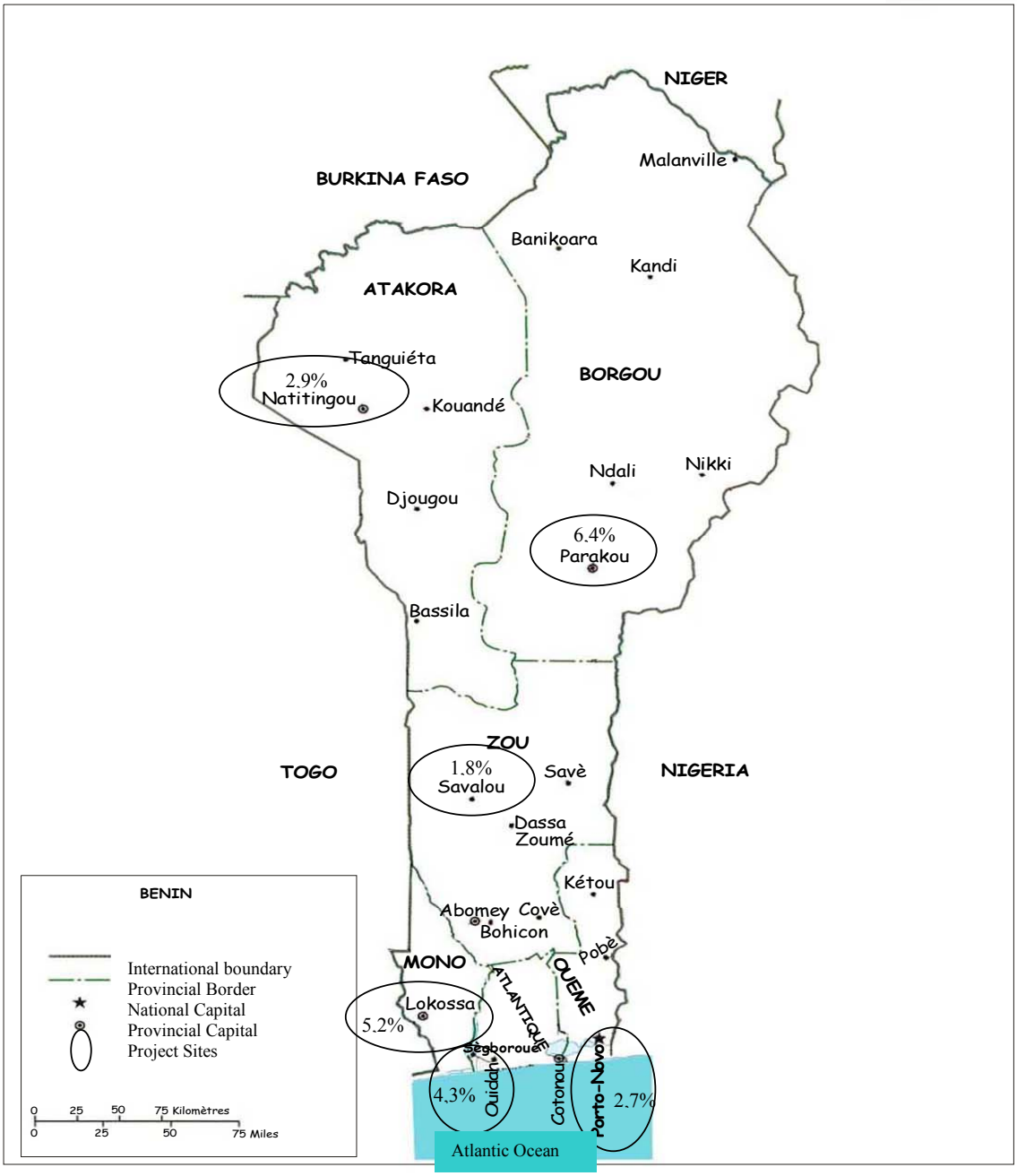
The Donee shall, in addition:

i) Submit to the Fund, not later than 3 months after the first disbursement, a copy of the manual of administrative, accounting and financial procedures, the draft of which shall be acceptable to the Fund, (paragraph 5.1.5);

ii) Submit to the Fund, no later than end January of each year, a detailed programme of training activities envisaged for financing under the project (paragraph 4.6.9).

Benin

Map showing location of the AIDS Control Support Project



BENIN
HIV/AIDS CONTROL SUPPORT PROJECT
ESTIMATED HIV/AIDS PREVALENCE RATES AMONG ADULTS (15-45 years) in regional member countries (2002-2003)

	COUNTRY	RATE (%)
1.	**Algeria**	0.1
2.	**Angola**	5.5
3.	**Benin**	3.6
4.	**Botswana**	38.8
5.	**Burkina Faso**	**6.5**
6.	**Burundi**	8.3
7.	**Chad**	3.6
8.	**Cameroon**	11.8
9.	**Cape Verde**	-
10.	**Central Africa Rep.**	12.9
11.	**Comoros**	0.12
12.	**Congo**	7.2
13.	**Cote d'Ivoire**	9.7
14.	**Djibouti**	11.75
15.	**Egypt**	0.02
16.	**Eritrea**	2.8
17.	**Ethiopia**	6.4
18.	**Gabon**	4.16
19.	**Gambia**	1.6
20.	**Ghana**	3.0
21.	**Guinea**	1.54
22.	**Guinea Bissau**	2.8
23.	**Guinea Equatorial**	0.51
24.	**Kenya**	15.0
25.	**Lesotho**	31.0
26.	**Liberia**	2.8
27.	**Libya**	0.2
28.	**Madagascar**	0.3
29.	**Malawi**	15.0
30.	**Mali**	1.7
31.	**Morocco**	0.1
32.	**Mauritania**	0.52
33.	**Mauritius**	0.1
34.	**Mozambique**	13.0
35.	**Namibia**	22.5
36.	**Niger**	1.35
37.	**Nigeria**	5.8
38.	**Rwanda**	8.9
39.	**Senegal**	0.5
40.	**Seychelles**	-
41.	**Sierra Leone**	7.0
42.	**Somalia**	1.0
43.	**Sudan**	2.6
44.	**South Africa**	20.1
45.	**Sao Tome & Principe**	-
46.	**Swaziland**	33.4
47.	**Tanzania**	7.8
48.	**Togo**	6.0
49.	**Tunisia**	0.04
50.	**Uganda**	5.0
51.	**Democratic Rep. of Congo**	4.9
52.	**Zambia**	21.5
53.	**Zimbabwe**	33.7
	AFRICA	**8,6**

Source: UNAIDS Epi Fact Sheets by Country – 2002 Updates

ANNEX III

BENIN
HIV/AIDS control support project
Overview of the MDG situation in Benin

Goals	Will the object be attained ?	Environmental Framework
Goal 1 : Eliminate extreme poverty and hunger		
Target 1 : Halve the proportion of the Beninese population living below the poverty line by bringing the poverty index to 15% by 2015	Potentially	Average
Target 2 : Reduce by 50% the number of people suffering from malnutrition by 2015	Potentially	Average
Goal 2 : Ensure primary education for all		
Target : Ensure primary school attendance for all children of school-going age by 2015	Probably	Strong
Goal 3 : Promote gender equality and women empowerment		
Target 4 : Eliminate gender disparities in primary and secondary schools by 2005 and at all educational levels by 2015 at the latest	Probably	Average
Goal 4 : Reduce mortality in children under 5		
Target 5 : Reduce infant and juvenile mortality rates from 166.5 per thousand in 1996 to 90 per thousand in 2015	Potentially	Average
Goal 5 : Improve maternal health		
Target 6 : Reduce maternal mortality rates from 498 for every hundred thousand live births in 1996 to 390 for every hundred thousand live births in 2015	Potentially	Average
Goal 6 : Fight HIV /AIDS, malaria and other diseases		
Target 7 : Reduce the prevalence of STI/HIV/AIDS	Potentially	Average
Target 8 : To have rolled back malaria and other diseases and begun to reverse the current trend by 2015	Potentially	Average
Goal 7 : Ensure a sustainable environment		
Target 9 : Mainstream the principle of sustainable development into national policies and reverse the current trend towards wasting of environmental resources	Potentially	Average
Target 10 : Halve the percentage of the population without access to sustainable drinking water supply by 2015	Probably	Average
Target 11 : Succeed in raising significantly the living standard of at least 2/3 of Beninese slum dwellers by 2015	Potentially	Average
Goal 8 : Establish global partnership for development		
Target 12 : Address the particular needs of the least developed countries	Potentially	Weak but improving

BENIN : HIV/AIDS CONTROL SUPPORT PROJECT

ANNEX IV

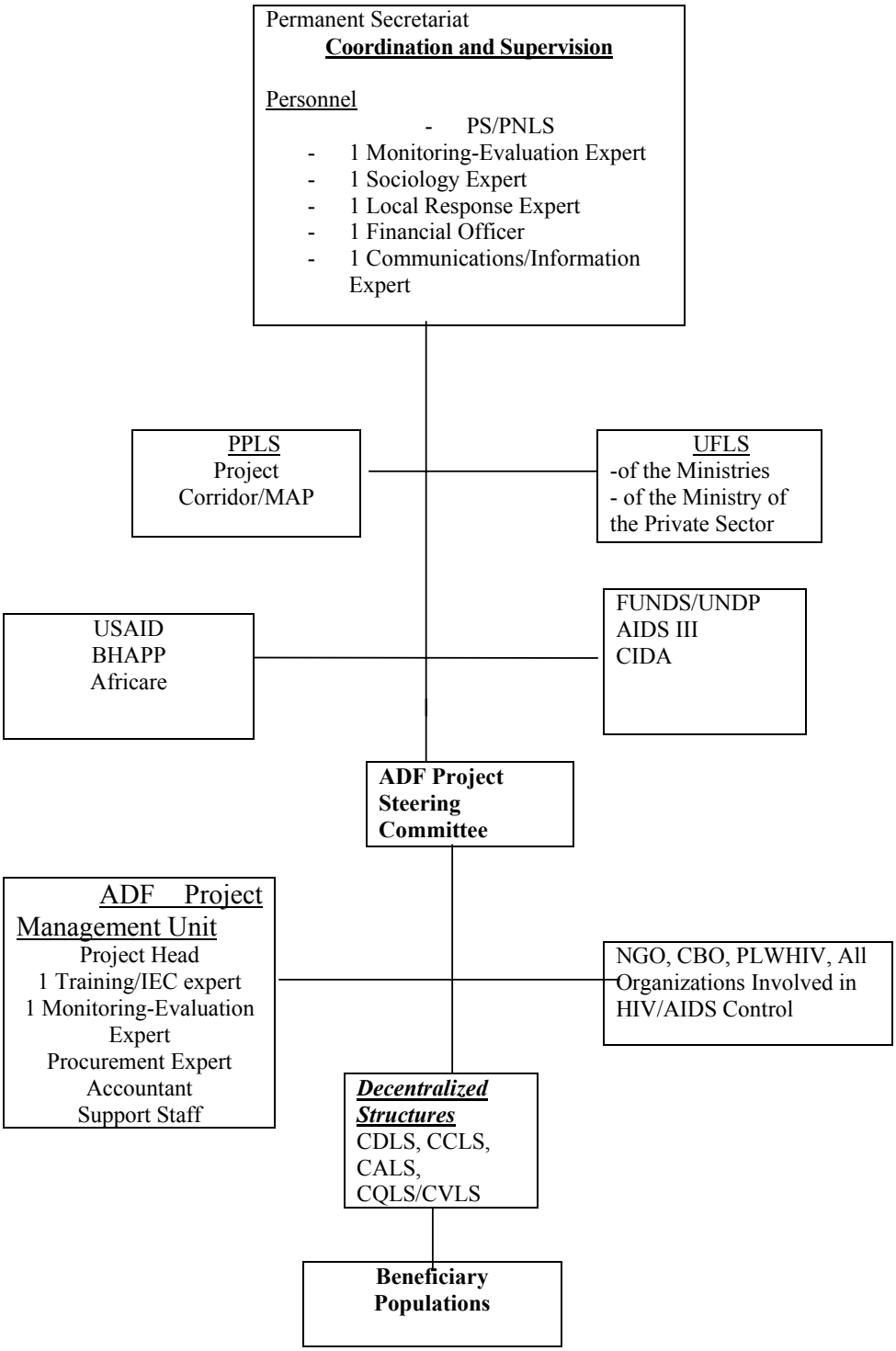
BENIN : ONGOING BANK PROJECTS AS AT 20/02/04 (in UA)

	Project	Approval Date	Sign. date	Compl. Date	Effectiv. Date	Date Last Disburs.	Approved Amount	Signed Amount	Undisbursed Amount	Disbursed Amount	Net Commit.	Disbu. Rate
1	FUELWOOD PROJECT - PHASE II (PBF II)	10/31/2001	12/21/2001	06/30/2008	12/31/2002		10,000,000.00	10,000,000.00	10,000,000.00	0.00	10,000,000.00	0.0
2	FOREST DEVELOPMENT PROJECT	01/20/2000	03/24/2000	12/31/2005	04/18/2001	11/28/2003	10,540,000.00	10,540,000.00	8,592,890.90	1,947,109.10	10,540,000.00	18.5
3	LIVESTOCK PROJECT III	12/15/1997	02/05/1998	12/30/2004	11/26/1999	09/04/2003	8,000,000.00	8,000,000.00	1,824,594.85	6,175,405.15	8,000,000.00	77.2
4	ARTISANAL FISHERIES SUPPORT PROGRAMME	11/27/2002	12/23/2002	12/31/2009	01/10/2004	02/19/2004	7,310,000.00	7,310,000.00	7,114,498.99	195,501.01	7,310,000.00	2.7
5	OUEME RURAL DEVELOPMENT SUPPORT PROJECT (PHASE II	10/07/1999	01/13/2000	12/31/2006	01/01/2002	12/12/2003	11,680,000.00	11,680,000.00	10,554,502.77	1,125,497.23	11,680,000.00	9.6
6	MONO AND COUFFO RURAL DEV. SUPPORT (PADMOC)	04/18/2001	05/30/2001	12/31/2009	12/29/3798	09/30/2003	9,130,000.00	9,130,000.00	8,740,088.35	389,911.65	9,130,000.00	4.3
	Agriculture Sector Total						***56,660,000.00***	***56,660,000.00***	***46,826,575.86***	***9,833,424.14***	***56,660,000.00***	***17.4***
7	COTONOU-PORTO NOVO ROAD EMERGENCY REH. PROJECT	09/11/1996	09/23/1996	12/31/2002	03/03/1999	11/07/2002	10,000,000.00	10,000,000.00	2,524,294.85	7,475,705.15	10,000,000.00	74.8
7	COTONOU-PORTO NOVO ROAD EMERGENCY REH. PROJECT	09/04/1996	09/23/1996	12/31/2002	03/29/1999	02/03/2003	6,000,000.00	6,000,000.00	1,771,167.31	4,228,832.69	6,000,000.00	70.5
8	POBE-KETOU-ILLARA ROAD STUDY	10/07/1999	01/13/2000	12/30/2002	04/21/2000	11/28/2003	590,000.00	590,000.00	337,276.76	252,723.24	590,000.00	42.8
9	Djougou-Ndali Road Rehabilitation Project	07/22/2003	12/01/2004	21/12/2007			11,110,000.00	11,110,000.00	11,110,000.00	0.00	11,110,000.00	0.0
9	Djougou-Ndali Road Rehabilitation Project	07/22/2003	01/12/2004	12/31/2007			4,000,000.00	4,000,000.00	4,000,000.00	0.00	4,000,000.00	0.0
	Transport Sector Total						***31,700,000.00***	***31,700,000.00***	***19,742,738.92***	***11,957,261.08***	***31,700,000.00***	***37.7***
10	RURAL ECTRIFICATION PROGRAMME	06/28/2000	07/26/2000	12/31/2004	12/29/3798	10/31/2003	4,800,000.00	4,800,000.00	3,981,964.52	818,035.48	4,800,000.00	17.0
11	SECOND RURAL ELECTRIFICATION PROGRAMME	10/29/2003	01/12/2004	12/31/2008			12,320,000.00	12,320,000.00	12,320,000.00	0.00	12,320,000.00	0.0
	Public Utilities Total						***17,120,000.00***	***17,120,000.00***	***16,301,964.52***	***818,035.48***	***17,120,000.00***	***4.8***
12	CONST. REGIONAL PUBLIC HEALTH INSTITUTE	05/02/1991	05/09/1991	03/30/2003	02/15/1994	11/21/2003	9,210,520.00	9,210,520.00	562,607.80	8,647,912.20	9,210,520.00	93.9
13	PROMOTION ACTIVITES ECONOMIQUES FEMMES DE OUEME	12/12/1996	02/07/1997	12/31/2004	10/01/1998	09/30/2003	2,000,000.00	2,000,000.00	1,512,152.34	487,847.66	2,000,000.00	24.4
14	EDUCATION PROJECT III	12/15/1997	02/05/1998	06/30/2005	06/30/1999	02/25/2004	8,000,000.00	8,000,000.00	3,277,336.12	4,722,663.88	8,000,000.00	59.0
15	EDUCATION IV	12/04/2002	12/23/2002	12/31/2008	02/12/2004	-	12,000,000.00	12,000,000.00	12,000,000.00	0.00	12,000,000.00	0.0
16	HEALTH PROJECT II	08/31/1993	01/20/1994	06/30/2003	01/27/1995	01/15/2004	7,370,000.00	7,370,000.00	1,626,021.21	5,743,978.79	7,370,000.00	77.9
17	HUMAN RESOURCES DEVELOPMENT PROGRAMME	03/15/2000	07/11/2000	12/31/2005	10/102001	02/19/2004	10,000,000.00	10,000,000.00	9,115,550.45	884,449.55	10,000,000.00	8.8
17	HUMAN RESOURCES DEVELOPMENT PROGRAMME (Grant)	03/15/2000	07/11/2000	12/31/2005	10/102001	02/16/2004	2,000,000.00	2,000,000.00	1,775,804.47	224,195.53	2,000,000.00	11.2
	Social Sector Total						***50,580,520.00***	***50,580,520.00***	***29,869,472.39***	***20,711,047.61***	***50,580,520.00***	***40.9***
18	POVERTY REDUCTION STRATEGY SUPPORT PROGRAMME	12/10/2003	01/12/2004	12/31/2006			23,290,000.00	0.00	0.00	0.00	23,290,000.00	0.0
18	POVERTY REDUCTION STRATEGY SUPPORT PROGRAMME	12/10/2003	01/12/2004	12/31/2006			1,000,000.00	0.00	0.00	0.00	1,000,000.00	0.0
	Total Multisector						***24,290,000.00***	***0.00***	***0.00***	***0.00***	***24,290,000.00***	***0.0***

ANNEX V

BENIN
HIV/AIDS CONTROL SUPPORT PROJECT

Organization Structure of the National HIV/AIDS Control Commission and the ADF Project Management Unit



ANNEX - VI

BENIN - HIV/AIDS CONTROL SUPPORT PROJECT
DETAILED PROJECT IMPLEMENTATION SCHEDULE / Quarter

	2004		2005				2006				2007				2008		
Activities	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**3**	**4**	**1**	**2**	**Responsibility**
Board Presentation	X																ADB
Signing of Protocol Agreement	X																ADF / Government
Effectiveness			X														ADF / Government
I. SUPPORT TO PREVENTIVE ACTIVITIES AND TRADITIONAL MEDICINE																	
Selection of CBOs, Associations and NGOs			X														ADF / Government / PS-CNLS / PNLS
Approval of IEC Activities to be Carried Out by the CBOs, Associations & NGOs				X													ADF / Gov. /PS-CNLS / PNLS / NGO & CBO
Implementation of Activities to be Implemented by CBOs, Associations & NGOs					X	X	X	X	X	X	X	X	X	X			ADF / Gov. / PS-CNLS / PNLS / NGO and CBO
Strengthening of Serosurveillance (PNLS)			X	X	X	X	X	X	X	X	X	X	X	X			ADF / Gov. / PS-CNLS / PNLS
Voluntary Screening Activities			X	X	X	X	X	X	X	X	X	X	X	X			ADF / Gov. / PS-CNLS / PNLS / NGO & CBO
Implementation of PRETRAME in 6 Maternities			X	X	X	X	X	X	X	X	X	X	X	X			ADF / Gov. / PS-CNLS / PNLS
Training of 600 Traditional Practitioners			X	X	X	X											ADF / Government / SP-CNLS / PNLS / UGP
II. SUPPORT TO HIV/AIDS-STI CONTROL STRUCTURES																	
Strengthening CBOs, Associations and NGOs			X	X	X	X	X	X	X	X	X	X	X	X			ADF / Government / PS-CNLS / UGP / Consultants
Institution Building in 6 Communes			X	X	X	X	X	X	X	X	X	X	X	X			ADF / Government /PS-CNLS / UGP / NGO & CBO
Approval of Training Plan			X														ADF / Government / SP-CNLS / PNLS
Training/Decentralized Structures (micro-planning, monitoring-evaluation and IEC)			X	X	X	X	X	X	X	X	X	X	X	X			ADF / Government / PS-CNLS / UGP / NGO & CBO
Training of CCLS, CALS and CVLS (micro-planning, monitoring-evaluation and IEC)			X	X	X	X	X	X	X	X	X	X	X	X			ADF / Government / PS-CNLS / UGP / NGO & CBO
Implementation of IEC Activities (including discussions & debates)			X	X	X	X	X	X	X	X	X	X	X	X			ADF / Gov./ PS-CNLS / PNLS / NGO & CBO
Approval of Study-Related Documents			X														ADF/Government
Conduct of Different Studies			X	X													SP-CNLS / UGP / Consultants
Production of HIV/AIDS Documentary			X	X													SP-CNLS / PNLS / UGP / Consultants
Training of Directors and Coordinators of 575 Development Projects				X				X				X					ADF / Government / PS-CNLS / UGP / Consultants
Institutional Building in PS-CNLS			X	X	X	X	X	X	X	X	X	X	X	X			ADF / Government / UGP / Consultants
III. PROJECT MANAGEMENT																	
Recruitment of Consultants for PMU	X	X															Government / PS-CNLS
Invitations for Applicants to Submit Offers	X																Government / PS-CNLS
Shortlists and Preparation of Bidding Documents	X																Government / PS-CNLS
Analysis of Applicants Offers		X															Government / PS-CNLS
Negotiations and Signing of Contracts with Consultants		X															Government / PS-CNLS
Consultants Missions			X	X	X	X	X	X	X	X	X	X	X	X			Consultants /PS-CNLS / PNLS
Approval of Detailed Activity Plans of Beneficiaries			X														ADF / Government
Implementation of Activities Included in the Plans			X	X	X	X	X	X	X	X	X	X	X	X			ADF / Gov./ PS-CNLS / UNDP / PNLS / NGO & CBO
ADF Non-Objection			X														ADF
Procurement of Furniture, Equipment & Liaison Vehicle/PMU			X														Government / PS-CNLS / Suppliers
Preparation of Drugs, Reagents, etc. / UNIPAC			X				X				X						Government / PS-CNLS
Preparation of Lists of Misc. Vehicles & Equipment/APSO			X														Government /PS-CNLS
ADF Non-Objection			X				X				X						ADF
Delivery and Distribution of Medicines, Reagents, etc. / UNIPAC				X	X			X	X			X	X				Government / UNDP
Delivery and Installation of Furniture & Misc. Equipment / IAPSO				X	X												Government / UNDP
Monitoring & Supervision of Project Activities					X		X				X		X		X		ADF / Gov./ PS-CNLS / UNDP / PNLS / NGO & CBO
Preparation of Quarterly Project Implementation Reports			X	X	X	X	X	X	X	X	X	X	X	X			ADF / Government
Annual Audits of Project Accounts							X				X				X		ADF / Government
Preparation of PCR by Government															X		Government
Preparation of PCR by the Bank																X	ADF

BENIN
HIV/AIDS CONTROL SUPPORT PROJECT

List of Goods and Services (in million UA)

CATEGORY of EXPENDITURE	ADF			Gov.	TOTAL			
	F.E.	L.C	Total	L.C	F.E.	L.C	Total	%
A / Goods	**0.93**	**0.00**	**093**	**0.00**	**0.93**	**0.00**	**0.93**	***33%***
Base cost	**0.86**	**0.00**	**0.86**	**0.00**	**0.86**	**0.00**	**0.86**	***30%***
Contingencies	***0.03***	***0.00***	***0.03***	***0.00***	***0.03***	***0.0000***	***0.03***	***1%***
Inflation	***0.03***	***0.00***	***0.03***	***0.00***	***0.03***	***0.0000***	***0.03***	***1%***
B / Services	**0.47**	**1.24**	**1.71**	**0.11**	**0.47**	**1.35**	**1.82**	***64%***
Base cost	**0.44**	**1.16**	**1.60**	**0.10**	**0.44**	**1.26**	**1.70**	***60%***
Contingencies	***0.02***	***0.05***	***0.06***	***0.004***	***0.02***	***0.05***	***0.07***	***2%***
Inflation	***0.01***	***0,03***	***0.05***	***0.003***	***0.01***	***0.04***	***0.05***	***2%***
C / Operating Expenses	**0.00**	**0,06**	**0.06**	**0.04**	***0.00***	**0.10**	**0.10**	***4%***
Base cost	**0.00**	**0,06**	**0.06**	**0.03**	***0.00***	**0.09**	**0.09**	***3%***
Contingencies	*0.00*	*0,002*	*0.00*	*0.001*	*0.00*	*0.04*	*0.004*	*0,1%*
Inflation	*0.00*	*0,002*	*0.00*	*0.001*	*0.00*	*0.003*	*0.003*	*0,1%*
Total project cost	**1.40**	**1,30**	**2.70**	**0.14**	**1.40**	**1.45**	**2.84**	***100%***
%	*49%*	*46%*	***95%***	*5%*	*49%*	*51%*	***100%***	

REPUBLIC OF BENIN
HIV/AIDS CONTROL SUPPORT PROJECT

COST SUMMARY
Exchange Rate (April/2004): 1 UA = CFA.F 794.462

No.	DESCRIPTION	TOTAL		
		CFAF	UA	%
I.	**SUPPORT FTO PREVENTIVE ACTIVITIES AND TRADITIONAL MEDICINE**	**1,003,666,915.46**	**1,263,329.04**	**44.5%**
I.A.	Goods	490,589,441.00	617,511.52	21.7%
I.B.	Services	447,417,022.05	563,169.82	19.8%
	Total Base Cost (Component I)	**938,006,463.05**	**1,180,681.35**	**41.5%**
	Contingencies (4%)	*37,520,258.52*	*47,227.25*	*1.7%*
	Price Contingency (3%)	*28,140,193.89*	*35,420.44*	*1.2%*
I.1.	***Preventive Activities***	***837,528,991.00***	***1,054,209.00***	***37.1%***
I.1.A.	Goods	490,589,441.00	617,511.52	21.7%
I.1.B.	Services	346,939,550.00	436,697.48	15.4%
I.1.1.	*IEC/Service delivery by NGOs, CBO and Associations*	*206,471,400.00*	*259,888.33*	*9.1%*
I.1.1.A.	Goods	0.00	0.00	0.0%
I.1.1.B.	Services	206,471,400.00	259,888.33	9.1%
I.1.2.	*PNLS /Epidemiological Surveillance*	*171,000,000.00*	*215,240.00*	*7.6%*
I.1.2.A.	Goods	66,000,000.00	83,075.09	2.9%
I.1.2.B.	Services	105,000,000.00	132,164.91	4.7%
I.1.3.	*Screening*	*288,547,441.00*	*363,198.54*	*12.8%*
I.1.3.A.	Goods	288,547,441.00	363,198.54	
I.1.3.B.	Services	0.00	0.00	0.0%
I.1.4.	*PRETRAME*	*171,510,150.00*	*215,882.13*	*7.6%*
I.1.4.A.	Goods	136,042,000.00	171,237.89	6.0%
I.1.4.B.	Services	35,468,150.00	44,644.24	1.6%
I.2.	***Traditional Medicine***	***68,760,000.00***	***86,549.14***	***3.0%***
I.2.B.	Services	68,760,000.00	86,549.14	3.0%
I.3.	***Administrative Cost of UNIPAC and IAPSO***	***31,717,472.05***	***39,923.21***	***1.4%***
I.3.B.	Services	31,717,472.05	39,923.21	1.4%
II.	**SUPPORT TO HIV/AIDS-STI CONTROL FACILITIES**	**848,689,829.55**	**1,068,257.30**	**37.6%**
II.A.	Goods	143,760,000.00	180,952.64	6.4%
II.B.	Services	649,408,065.00	817,418.66	28.8%
	Total Base Cost (Component II)	**793,168,065.00**	**998,371.31**	**35.1%**
	Physical Contingencies (4%)	*31,726,722.60*	*39,934.85*	*1.4%*
	Price Contingency (3%)	*23,795,041.95*	*29,951.14*	*1.1%*
II.1.	***NGOs, CBO and Associations***	***174,600,000.00***	***219,771.37***	***7.7%***
II.1.A.	Goods	0.00	0.00	0.0%
II.1.B.	Services	174,600,000.00	219,771.37	7.7%
II.2.	***6 Communes***	***433,606,565.00***	***545,786.41***	***19.2%***
II.2.A.	Goods	104,400,000.00	131,409.68	4.6%
II.2.B.	Services	329,206,565.00	414,376.73	14.6%
II.3.	***National Level***	***57,642,500.00***	***72,555.39***	***2.6%***
II.3.A.	Goods	0.00	0.00	0.0%
II.3.B.	Services	57,642,500.00	72,555.39	2.6%
II.4.	***PS/CNLS***	***127,319,000.00***	***160,258.14***	***5.6%***
II.4.A.	Goods	39,360,000.00	49,542.96	1.7%
II.4.B.	Services	87,959,000.00	110,715.18	3.9%
III.	**PROJECT MANAGEMENT**	**405,587,860.81**	**510,518.89**	**18.0%**
III.A.	Goods	52,514,000.00	66,100.08	2.3%
III.B.	Services	252,626,999.52	317,985.00	11.2%
III.C.	Operation	73,913,076.00	93,035.38	3.3%
	Total de Base (Composante III)	**379,054,075.52**	**477,120.46**	**16.8%**
	Physical Contingencies (4%)	*15,162,163.02*	*19,084.82*	*0.7%*
	Price Contingency (3%)	*11,371,622.27*	*14,313.61*	*0.5%*
III.1.	***Project Management Unit***	***379,054,075.52***	***477,120.46***	***16.8%***
III.1.A.	Goods	52,514,000.00	66,100.08	2.3%
III.1.B.	Services	252,626,999.52	317,985.00	11.2%
III.1.C.	Operation	73,913,076.00	93,035.38	3.3%
	Project Base Cost	**2,110,228,603.57**	**2,656,173.11**	**93.5%**
A	Goods	686,863,441.00	864,564.25	30.4%
B	Services	1,349,452,086.57	1,698,573.48	59.8%
C	Operation	73,913,076.00	93,035.38	3.3%
	Physical Contingencies (4%)	*84,409,144.14*	*106,246.92*	*3.7%*
	Price Contingency (3%)	*63,306,858.11*	*79,685.19*	*2.8%*
	Project Total	**2,257,944,605.82**	**2,842,105.23**	**100.0%**
A	Goods	734,943,881.87	925,083.74	32.5%
B	Services	1,443,913,732.63	1,817,473.63	63.9%
C	Operation	79,086,991.32	99,547.86	3.5%
	ADB	**2,145,047,396.32**	**2,700,000.00**	**95.0%**
	Government	**112,897,209.50**	**142,105.24**	**5.0%**

Total Financing **2,842,105**

BENIN
HIV/AIDS CONTROL SUPPORT PROJECT

TERMS OF REFERENCE

PROJECT OFFICER

1. Function.

The Project Officer shall be ensure the effective management of the project. He/she shall, to that end, see to it that the project resources are used in a rational manner that will guarantee attainment of the objectives in terms of its expected outcomes.

2. Duties.

The specific duties of the Project Officer shall be to:

(a) Participate in the recruitment of the other PMU senior staff in accordance with the relevant Bank procedures;
(b) Coordinate all aspects of project implementation and ensure that all activities are implemented within the set timeframes;
(a) Ensure that all staff of the PMU carry out their duties efficiently;
(b) Participate in organizing procurement procedures for goods and services;
(c) Ensure satisfactory and regular flow of funds for the different activities;
(d) Ensure proper project accounting and prepare disbursement requests;
(e) Ensure the regular payment of counterpart funds by the Government;
(f) Prepare regular activity reports for submission to the officers responsible for MSP component, and to the Bank;
(g) Help in the preparation of the Government's project completion report (PCR) and assist the Bank in preparing its PCR

3. Qualifications

(a) Qualification as Doctor of Medicine or Health Economist;
(b) A minimum of 6 (06) months supervisory experience in managing development projects or equivalent management position;
(c) Good knowledge of the community-based approach, human resource management and gender issues.

TERMS OF REFERENCE
MONITORING/EVALUATION SPECIALIST

1. Function.

The Monitoring-Evaluation Specialist shall oversee effective monitoring/evaluation of the project activities, performance and indicators.

2. Duties

The specific duties of the Monitoring/Evaluation Specialist are to:

(a) Assist in establishing a project monitoring/evaluation system;
(b) Monitor the project indicators as defined in the project matrix and those from the ex ante study;
(c) Organize and oversee the monitoring –evaluation unit of the decentralized structures working on the project (focal point, communes) ;
(d) Centralize the quarterly and annual reports of the decentralized structures;
(e) Prepare quarterly and annual project reports;
(f) Assist in preparing terms of reference for the studies planned under the project;
(g) Support the consultants in the implementation of their mission;
(h) Train officers responsible for monitoring- evaluation in the project's decentralized structures;
(i) Provide technical assistance to the decentralized structures in drawing up their action plans

3. Qualifications

(i) Medical doctor, specialist in public health/ Economist or Sociologist
(ii) At least six (06) years professional experience

BENIN
HIV/AIDS CONTROL SUPPORT PROJECT

TERMS OF REFERENCE

TRAINING/INFORMATION/EDUCATION/COMMUNICATION EXPERT (IEC)

1. Functions

The training/IEC expert will be responsible for drawing up modules (or for using existing modules) for both training and IEC. He shall, in addition, monitoring the quality of all the project activities pertaining to training and IEC.

2. Duties

(a) Advise the Project Officer on training and IEC issues;
(b) Draw up training modules that do not yet exist;
(c) Assist the different structures involved in the project to draw up their proposals for training under the project;
(d) Assist the Procurement Officer to finalize shortlists for the recruitment of trainers;
(e) Evaluate the performance of the trainers;
(f) Consolidate the annual training programme to be sent to the Bank;

3. Qualifications

- Masters in social sciences, and not less than 6 (06) years experience in training and IEC;

BENIN

HIV/AIDS CONTROL SUPPORT PROJECT

TERMS OF REFERENCE

ACCOUNTS MANAGER

1. Functions.

The Accounts Manager shall be responsible for day-to-day accounting and for preparing accounting audits of the implementation of the project.

2. Duties

(a) monitor adequate provisioning of the accounts so as to ensure speedy settlement of expenses incurred ;
(b) keep regularly updated financial documents (ledgers and books of account) and detailed accounts for each category of expenditure, component and sub-component ;
(c) prepare and follow up on payment invoices;
(d) prepare, in accordance with Bank procedure, fund withdrawal requests and all documents in support of disbursements, ;
(e) prepare monthly statements, bank reconciliation statements in respect of the special project account ; keep updated records of the financial position for each component ;
(f) carry out goods accounting in respect of the project;
(g) keep a computerized accounting system, prepare and update accounts, financial statements and the project specifications .

3. Qualifications

- Advanced training in accounting;
- At least six (06) months experience in the accounts department handling equivalent amounts in annual cash flow;
- Familiarity with disbursement rules and procedures for similar projects having several components and sub-components desirable;
- Must be familiar with accounting softwares.

TERMS OF REFERENCE
PROCUREMENT OFFICER

1. Functions

The Procurement Officer shall be based in the PMU in Niamey and shall carry out the following duties:

2. Duties

The duties of the Procurement Officer shall be as follows:

(a) Prepare detailed activity programmes relating to the procurement of goods and services for the project;

(b) Prepare BDs and CIs for the bidding procedure and transmit them to the ADF;

(c) Prepare documents relating to procurements to be made through UNIPAC and IAPSO, and monitor the process;

(d) Monitor the process of procurement and dispatching of furniture and equipment o the implementation of the different project components;

(e) Update the activity schedule to ensure synchronized implementation of the different categories of project activity;

(f) Monitor project implementation closely using quarterly timetables and reports prepared by each of the different players and ensure compliance with Bank bidding procedures;

(g) Ensure payment of contractors and fund disbursement are carried out within the at the appointed time;

(h) Assist in the preparation of the project completion report

3. Qualifications

(a) Degree in construction engineering or Masters in Law with knowledge of administration and project management;

(b) At least six (06) months experience of contract award procedures and management of donor-funded projects in developing countries (preferably in Africa) ;

(c) Knowledge of planning, programming and budgeting procedures;

(d) Familiarity with project implementation data processing softwares;

(e) Ability to work as part of team.

Fluency in French is mandatory for each of these positions.