



Republic of Benin

**Ministry of Justice, in charge of institutional relations
MJ-CRI**

A WORLD FIT FOR CHILDREN

**MID-TERM REVIEW OF PROGRESS
IN REACHING OBJECTIVES
(Activities 2003-2006)**

NATIONAL REPORT - BENIN

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UN MONDE DIGNE DES ENFANTS

SUMMARY

Drafting the national report involved the participation of more than 70 resource-persons (State structures, development partners, civil society and youths) who contributed during interviews, identifying documents and making some of them available as well as taking part in the validation meeting and the final drafting of the report.

The principal activities undertaken in achieving the targets of the MDGs were the implementation of the Poverty Reduction Strategy Paper (PRSP 2003-2005), which will be followed up by the PRSP-II presently being finalised for 2007-2011. Several important planning initiatives were approved, notably: the Health Sector Policy (2002-2006), the Ten Year Educational Plan (2006-2015) and the Strategic Framework to Combat HIV/AIDS/STI. Some laws related to a WFFC were enacted including the Persons and Family Code, the Suppression of Child trafficking and the Banning of female genital mutilations.

Financial resources made available for children were generally increased, coming from the National Budget, external aid, debt relief NGOs as well as from Local Authorities and local communities. The major problem identified was the low capacity to use available funds. The economic slowdown which occurred as from 2002 has limited the availability of budgetary funds.

The monitoring of WFFC / MDGs targets was considerably improved during the period. It is done mainly through monitoring of the PRSP implementation and reports on progress towards the MDGs undertaken respectively by the Permanent Secretariat of the National Commission for Development and Combating Poverty (CNDLP) and the Observatory of Social Change (OCS), as well as by Civil Society. Regular surveys include the 3rd Census of Population and Housing (2002), the 2006 Demographic and Health survey (DHS) taking place simultaneously with the Modular Household Survey on Living Conditions (EMICOV), presently under way. Other information sources are the QUIBB survey, the BenInfo database and the Observatory of the Family as well as the alternative reports drawn up by the civil society.

The improvement of partnerships and alliances for children includes an increase in external financial resources made available and the improvement of coordination resulting from setting up or strengthening of interministerial structures (CNDLP, CNLS...), the development of government-civil society partnerships and new civil society networks as well as technical and financial partnerships.

The achievement of MDGs targets related to the WFFC Action Plan seems to be possible only for primary schooling, reducing children's underweight and access to clean water supply. However, numerous relevant activities undertaken since the start of 2003, coupled with an obvious increase in political will (shown through decisions such as making primary and preschool education free or the clearer targeting of the MDGs in the PRSP-II) show that possibilities exist for a more favourable evolution.

In the **Health** field, major achievements are the on-going efforts to implement new strategies to reduce neonatal and infant mortality, maintain high vaccination levels and introduce new vaccines, iodisation of salt, and the approval of policy and strategy documents. For **Education**, there has been an improvement of schooling levels, especially for girls and the approval of important planning documents, such as the National Plan for Education for All, the Letter on Educational Policy (2005) and the Ten Year Development Education (2006-2015). In the area of **Protection**, there has been an important effort to combat child trafficking with the signing of regional coordination agreements, the setting up of over 1 000 village committees and an overall study of the scope of traffic, the setting up of two new centres for children in conflict with the law, the enactment of several new laws and efforts to increase birth registration. The PMTCT, paediatric care for infected children and care of orphans and vulnerable children are all included in the new national Framework to **combat HIV/SID/ITS**, while PMTCT is being generalized and is already included in the current activities of 185 maternal and child health services.

Acronyms and abbreviations

| | |
|---------|--|
| ABAEF | Benin Association to Assist Children and the Family |
| ACAT | Christian Action to Abolish Torture |
| ACPE | Community Child Protection Action |
| ADB | African Development Bank |
| ADMAB | Association for the Development of Rural Social Mutual Associations in Benin |
| AEJT | Association of Working Children and Youths |
| AFJB | Association of Women Jurists in Benin |
| ANC | Antenatal consultancy |
| ARV | Anti retroviral drugs |
| ASSEF | Women's mutual aid Association |
| BCG | Anti tuberculosis vaccine |
| BN | National Budget |
| CADEMU | Center for the development of Mutual Health Associations |
| CARDER | Regional Center for Rural Development Action |
| CBDIBA | Benin Center for Developing Grass Roots Initiatives |
| CEP | Primary School Leaving Certificate |
| CIDR | International Center for Development and Research |
| CLOSE | Social Organizations Liaison Committee on Children's Rights |
| CLOSE | Liaison Committee of social organizations defending children's rights |
| CM2 | Primary school Grade 6 |
| CNDLP | National Commission for Development and to Combat Poverty |
| CNHU | National University Hospital |
| CNLS | National Committee to Combat AIDS |
| CNS | National Statistics Council |
| CPS | Social Protection Center |
| CRC | Convention on the Rights of the Child |
| CRS | Catholic Relief Services |
| CREDESA | Regional Center for Health Development |
| CREPA | Regional Center for Low Cost Water Supply and Sanitation |
| CWIC | Core Welfare indicator Questionnaire |
| DANA | Applied Nutritional Department |
| DANIDA | Danish Agency for International Development Assistance |
| DE | Environment Department |
| DEI | Children's Defence International |
| DGH | Hydraulics Department |
| DHAB | Hygiene and Sanitation Department |
| DHS | Demographic and Health Survey |
| DPJEJ | Department for Legal Protection of Children and Youths |
| DPJEJ | Direction of Legal Protection of Childhood and Youth |
| DPT3 | Diphtheria – Pertussis – Tetanus, 3rd dose |
| ECCAS | Economic Community of Central African States |
| ECOWAS | Economic Community of West African States |
| EPI | Enlarged Programme of Immunization |
| EPT | Education for all |
| EU | European Union |
| FGM | Female Genital Mutilation |
| GAVI | Global Alliance for Vaccines and Immunization |
| GNP | Gross National Product |
| GRAPAD | Research and Action Group for Agriculture and Development |
| GROPERE | Group Promoting Environmental Resource Use |
| GSR | Gross Schooling Ratio |

| | |
|--------------|--|
| GTZ | Deutsche Gessellschaft fur Technische Zusammenarbeit |
| HIPC | Heavily indebted poor countries |
| HIV/AIDS | Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome |
| HPI | Hulman Poverty Index |
| IEC-CC | Information, Education and Communication for Behavioural Change |
| ILO-IPEC | International Labor Office-International Program to combat Trafficking in Children for Labor Exploitation |
| ILO-STEP | International Labor Office-Strategies and Techniques against Social Exclusion and Poverty |
| IMCI | Integrated Management of Child Illnesses |
| IMR | Infant Mortality Ratio |
| INSAE | National Institute for Statistics and Economic Analysis |
| IWRM | Integrated Management of Water Resources |
| LA | Local authority |
| LDH | League for Human Rights |
| MAEP | Ministry of Agriculture, Animal Production and Fishing |
| MCI | Micro Credit Institution |
| MD | Decentralisation Mission |
| MDCULRF-LCEC | Minister delegate in charge of Urban Development, Housing, Land reform and Combating Coastal Erosion |
| MDCULRF-LCEC | |
| MDG | Millennium Development Goals |
| MECCAG-PDPE | Ministry of State in charge of Coordinating Governmental Action, Prospective, Development and Promoting Employment |
| MEHU | Ministry of Environment, Housing and Urban Development |
| MEN | Ministry of National Education |
| MEPS | Ministry of Primary and Secondary Education |
| MFFE | Ministry of the Family, Women and Children |
| MFPSS | Ministry of the Family, Social Protection and Solidarity |
| MJ-CRI | Ministry of Justice, in charge of Relations with Institutions |
| MJLDH | Ministry of Justice, Legislation and Human Rights |
| MMEH | Ministry of Mines, Energy and Hydraulics |
| MMR | Maternal Mortality Ratio |
| MNNC | Maternal and Neo Natal Care |
| MP | Member of Parliament |
| MS | Ministry of Health |
| MSP | Ministry of Public Health |
| NGO | Non Government Organization |
| NLTPS | National Long Term Perspective Studies |
| NSR | Net Schooling Ratio |
| OCS | Observatory of Social Change |
| ODIP | Organisation to Defend Prisoners Interests |
| OMCT | World Organisation to Combat Torture |
| OVC | Orphans and Vulnerable Children |
| PAMR | Support Projet to the Rural World (Borgou) |
| PARMEC | Support Projet to Regulate Savings and Credit Mutual Associations |
| PASCIB | Platform of Civil Society Actors in Benin |
| PEE | Essential Educational Package |
| PLWHA | People living with HIV/AIDS |
| PMTCT | Prevention of mother to child transmission |
| PNDC | National Community Development Program |
| PNDCC | National Program for Community Driven Development |
| PNLP | National Program to Combat Malaria |
| PNLS | National Program to Combat AIDS |
| PRODECOM | Support Program to Local Authorities Start-Up |

| | |
|---------|---|
| PROMUSA | Support Program to Mutual Health Associations in Africa |
| PRS | Poverty Reduction Strategy |
| PRSP | Poverty Reduction Strategy Paper |
| RAVEC | Administrative Census for Civil Registration |
| RESPED | Network of Structures to Protect Children in Difficulty |
| RESPESD | Network of organizations protecting children in difficult circumstances |
| RGPH3 | Third General Population and Housing Census (2002) |
| SBEE | Benin Electrical Energy Society |
| SCN | Standing Committee on Nutrition |
| SNV | Dutch Development Organization |
| SP | Permanant Secretariat |
| STI | Sexually Transmitted Infections |
| SUO | United Sisters at Work |
| TBS | Social Monitoring Tables |
| U5MR | Under 5 Mortality Rate |
| UCD | Community Development Unit |
| UN | United Nations |
| UNAIDS | Joint United Nations Program on HIV/AIDS |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations Children's Fund |
| UNS | United Nations System |
| WB | World Bank |
| WFFC | World Fit for Children |
| WFP | World Food Program |

1. Introduction

The report has been drafted under the aegis of the Direction of Legal Protection of Childhood and Youth in the Ministry of Justice, in charge of Institutional Relations (DPJEJ/MJ-CRI). Support for preparing the report was provided by UNICEF which made available to the Ministry a consultant with experience in issues related to children and the development situation in Benin¹ and also provided logistic support. Meetings with the DPJEJ and exchanges with UNICEF led to a decision on the working procedures adopted.

An earlier discussion with the Children's Parliament was organized on the topic of a World Fit for Children (WFFC) and on children's involvement in the drafting of the Mid-Term National Report as well as in reaching the objectives of a WFFC.

A meeting to launch the reporting process was attended by 35 participants from Government services and civil society organizations. Progress in Benin during the Children's Decade (1990-2000), the 4 key priorities of a WFFC its interaction with the Millennium Development Goals (MDG) were presented as well as the procedures to be followed to draft the report. The meeting noted that little information was circulating on the WFFC and on the Government's commitment. During the organization of the meeting, contacts were made with over 40 other organizations and resource-persons involved in education, health, child protection and the combat against HIV/AIDS in order to explain the reporting procedure.

Information gathering was undertaken through interviews with organizations involved in the fields of education, health, nutrition, water supply and sanitation, child protection and HIV/AIDS, using an interview guide based on a shortened version of the WFFC overall Plan of Action. Many documents were made available, including a summary of statistics from BenInfo database.

During the period of information gathering, a meeting was held with apprentices, working children and pupils (25 children and youth of which 9 girls), including members of the Children's Parliament. After a reminder of the overall aims for a WFFC, they discussed their own involvement in improving the situation of all children in Benin. A film on child trafficking in Benin was also discussed. Working groups allowed children to give their opinion on their own experience of what has been done in Benin to improve children's situation and their own concerns in relation to the WFFC priorities as well as their ideas on the way to go further. They also stated that they wanted to be more fully informed on issues affecting them and be able to access communication supports enabling them to raise awareness of other young people in the networks in which they are involved as well as to think about the activities which they could undertake themselves in order to contribute to the achievement of the WFFC goals by Benin.

Analysis of information and drafting of the report was undertaken by the consultant's team following the recommended format as well as drawing up the statistical tables showing the evolution of progress made towards the WFFC goals and the MDGs. A **validation workshop** was held on the 8th December 2006.

Revision of the rapport and a technical meeting to finalize the national report, with representatives of various ministries and NGO networks (CLOSE, ABAEF/DEI) latest information available to be included.

¹ Support to preparation of National Report, Benin in December 2000 and to UNICEF report to UN Commission on Children's Rights.

2.- Principal activities undertaken in achieving the MDGs and the WFFC goals

The overall WFFC Plan of Action aims at achieving the MDGs which are specifically related to each of the 4 priority areas of action by 2015 (see Table 1). As well as targeting the MDGs, the overall Plan of Action also defines 16 objectives and 99 activities.

Table 1: MDGs relating to the WFFC priority areas of action

| World fit for Children | | Millennium Development Goals | |
|---|--------------------------|---|--|
| Promoting healthy lives | 7 goals 25 activities | MDG 1 (Target 1): Eradicate extreme poverty | |
| | | MDG 1 (Target 2): Eradicate hunger | |
| | | MDG 4 (Target 5): Reduce child mortality | |
| | | MDG 5 (Target 6): Improve maternal health | |
| | | MDG 6 (Target 8): Combat malaria and other diseases | |
| | | MDG 7 (targets 9, 11): Ensure environmental sustainability (Drinking water, sanitation, improved housing) | |
| Providing quality education | 6 goals 19 activities | MDG 2 (Target 3): Achieve universal primary education | |
| | | MDG 3 (Target 4): Promote gender equality and empower women | |
| | | MDG 1 (Target 1): Eradicate extreme poverty and hunger | |
| Protecting children against abuse, exploitation and violence | 47 activities | Millennium Declaration and other commitments in relation to child rights | |
| Combating HIV/AIDS | 3 goals 8 activities | MDG 6 (Target 7): Combat HIV/AIDS | |
| | | MDG 1 (Target 2): Eradicate hunger | |
| | | MDG 7 (Target 10): Access to drinking water and sanitation, | |

Source : MDG and WFFC Report

Development policies in Benin which target MDGs are based on a vision of development called the *Alafia Scenario* (MECCAG-PDPE – PNUD, 2000). Drawn up through a participatory process within the framework of the National Long Term Prospective Studies (NLTPS) undertaken before the Millennium Declaration, this document nevertheless takes account of the major themes of the MDGs.

Two mid term documents were directly inspired by the *Alafia Scenario*:

- The Government Plan of Action for 2001-2006 (BENIN, n.d.);
- The Poverty Reduction Strategy Paper 2003-2005 (PRSP-I), drawn up on the basis of ministerial sector reports and regional meetings, was approved by the governing councils of the World Bank and the International Monetary Fund in march 2003 (CNDLP, 2002). The PRSP-I presents the operational goals derived from the *Alafia Scenario* and aims at the MDGs targeted by the WFFC (cf. Table 1) as well as the improvement of overall socio-economic conditions which will create an enabling environment, in particular good governance and overall economic stability.

A new document (PRSP-II) is presently being finalized for 2007-2009. During a Forum to launch the process, held with all partners involved, the need to target unequivocally the MDGs was underlined.

Between 2002 and 2004, improved Government ownership of the MDGs aimed at setting up an operational follow-up mechanism for the poverty reduction strategy (PRS), now undertaken by the Permanent Secretariat of the National Commission for Development and to Combat Poverty (SP/CNDLP) and by the Observatory of Social Change (OCS), set up in early 2004. There is also increased dialogue and a common vision between development partners, Government, the private sector and civil society which aims at eradicating extreme poverty and in promoting development and good governance.

Although not specifically referring to the WFFC, the SRP clearly targets its 4 priority areas. Within this context, the implementation of national sector policies, strategies and programs contributing to the SRP has been the basis for the activities carried out in 2003-2006 which correspond to those called for in WFFC overall Plan of Action.

- In relation to the ***promotion of healthy lives***, the PRSP-I proposed strengthening health sector activities, principally:
 - Improving the coverage of health services and decentralizing the health care structures with de creation of District hospitals;
 - Mobilizing financial resources and improving their management;
 - Preventive care, combating priority diseases and improving service quality;
 - Promoting family health, reproductive health and the Integrated Management of Child Illness (IMCI)
 - Improving access to drinking water and environmental sanitation.

The PRSP-I also recommended a nutritional strategy based on, inter alia, weight monitoring, improvement of household food security, promoting breastfeeding (without specifying *exclusive* breastfeeding) and prevention action against micronutrient deficiencies. The Food and Nutritional Program run in partnership with the CRS by the MFFE through the Social Promotion Centers (CPS) developed a community based approach to these issues; a similar program was run by the MAEP/DANA through its regional centers (CARDER). The technical and finance support from the CRS having ended in 2006, the MFFE is actively researching alternative financial support for a new program.

Support for the PRS is provided by implementation of the 2002-2006 Health Sector Policy (MSP 2002), the Urban Drinking Water Supply Master Plan (SBEE, 2002), the Sanitation Policy (DHAB, 1995) and the National Program for Basic Hygiene and Sanitation (DHAB, 2003). Different health programs target improvements in the quality and accessibility of health services through community based activities, especially in relation to malaria. Taking care of poorer and destitute populations was to be covered by part of debt relief funds.

Several new national policies and strategies have been approved, including:

- The National Policy to Combat Malaria (2004) and its implementation through the Combat Strategy (2006-2010) and a monitoring and evaluation plan within the « Roll Back Malaria » framework;
- The National Strategy on Reducing Maternal and Neonatal Mortality (2006-2015);
- A National Integrated Communication Plan which aims at behavioural change;
- A Plan for the Financial Viability of the EPI (2005-2013) adopted in January 2005 which emphasizes country vaccination needs and resource mobilization strategies.

More recently, several initiatives have been taken to set up mutual health insurance groups (“mutuelles”) by Government services (Ministry of Labor and Civil Service), foreign partners (ADB, EU, UNICEF/ILO-STEP, Swiss Cooperation UNFPA, USAID) and civil society (ADMAB, ASSEF, Bethesda, Borne Fonden, CADEMU, CBDIBA, CIDR, CREDESA, Louvain Development Foundation, GROPERE, PROMUSA).

In addition, in December 2006, the Government declared its intention of making soon health care free of charge for children aged under 5 years old and pregnant women. In the legal field, a law was promulgated in 2003 on sexual and reproductive health.

- In relation to the ***provision of quality education***, the PSRP-I emphasized the 6 major aims of educational policy:
 - Equal chances for all;
 - Improving educational quality;
 - Rehabilitation of the institutional framework;
 - Training for self employment;

- Control of pupil and student movements at educational different levels;
- Cost control.

The PRS also proposed the development of technical and professional skills through non formal education, in particular through dual apprenticeship which will be organized by the trade training centers which were set up in the framework of the 1999 reform of technical and professional training. This strategy was confirmed by the law of the Orientation of National Education in 2003.

As a contribution to achievement of the MDGs and the goals of a WFFC in the field of education, several important policy and planning measures were taken over the last few years:

- Part of the debt relief funds were used as subventions to primary schools in order to improve access for poorer families;
- Government-partner dialogue led to the approval in 2005 of the Essential Educational Package to accelerate girl's education (PEE);
- Following the Government's commitment to the Action Framework agreed to at the Dakar Forum (2000), the principle of education for all was included in the National Education Orientation Law (November 2003), the National Plan on Education for All (2003), the Letter on Educational Policy (February 2005) and the Ten Year Development Plan for Education (2006-2015), which integrates the PEE and aims at achieving Universal Primary Education by 2015, was finalized and is presently being approved²;
- Reopening of 3 Teacher Training Colleges and a proposal to reopen 3 others with priority being given to training unqualified teachers recruited by local communities;
- Planning of accelerated educational opportunities for children over schooling age or having dropped out of school;
- A National Program to Promote Girls' Schooling;
- The generalization of new primary school curricula;
- A detailed study of a system of community based pre-school centers.

In addition, the Government abolished compulsory contributions for maternal and primary schooling in October 2006, an decision implemented for the 2006-2007 school year;

- Issues of **child protection** are dealt with more briefly in the PRSP-I, which calls for an improvement in family living conditions and the promotion of social stability. Under the heading of social protection, it provides for setting up and strengthening of local committees to combat child trafficking as well as the adoption of a Policy and Strategy Paper on social protection.

Covering the 2004-2013 period, that Paper was approved (MFPSS, n.d.) as a follow-up to the earlier National Policy on Women's Promotion (MFPSS, 2001) and the Multisectorial plan of Action to implement the policy (MSPSS, 2002). In addition, the Government presented the National Report to the United Nations' Commission Women's Rights and is presently implementing the Commission's recommendations by the different ministries concerned. The Government also presented its second periodical report to the United Nations' Commission on Children's Rights in September 2006 (MJLDH, 2002).

New legislation includes law n° 2006-04 of 30th January 2006 which defines conditions under which minors may travel and suppresses child trafficking while the Law on Sexual Harassment of 5th September 2006 reinforces the legal framework on an earlier interministerial order circular punishing sexual abuse and violence in schools. These laws are now being disseminated.

Other pertinent laws promulgated after being voted by Parliament were:

- The suppression of Female Genital Mutilation Practices (Law n°2003-03 of 3rd March 2003);

² This Plan will allow Benin to benefit from the World Bank's Fast Track Initiative.

- The Persons and Family Code (Law n° 2002-07 of 24th august 2004)³ ;
- The Prevention, Care and Control of HIV/AIDS (Law n° 2005-31).

Validated in October 2006, the project for a Children's Code is being checked for its conformity with the Convention on the Rights of the Child (CRC) by the MJCRI. The Paper on a Policy and Strategies for child protection is being drafted as well as a Plan of Action dealing specifically with child trafficking with a view to exploitation. Besides this, the Penal Code and the Penal Procedures Code are under revision.

In the field of international conventions and treaties, Benin has:

- Published the CRC in the Official Gazette in September 2006, which means that it has become an integral part of the national legislation;
 - Ratified the two Optional Protocols to the CRC as well as the UN Additional Convention against Transnational Organized Crime and its 3 additional protocols;
 - Signed a Bilateral Agreement of Cooperation with Nigeria⁴ in June 2005 to combat human trafficking, especially women and children, set up a Joint Committee and approved a Plan of Action in 2006 ;
 - Signed a multilateral agreement with 8 other countries (Burkina Faso, Côte d'Ivoire, Guinea, Liberia, Mali, Niger, Nigeria, Togo) on 27th July 2005 to combat child trafficking and a Sub-regional agreement on 7th July all the 26 member States of ECOWAS and ECCAS.
- The PRSP-I emphasized the combat against HIV/AIDS/STI as part of health activities, proposing a multisectorial approach in undertaking preventive measures, care for persons living with HIV/AIDS (including psychosocial support) and the monitoring of the situation, in conformity with the National Strategic Framework to Combat HIV/AIDS/STI 2000-2005 (PNLS-ONUSIDA, 2000).

The principle activities within this Framework were:

- A subvention for the care of people living with HIV/AIDS (PLWHA);
- Setting up public laboratories for rapid testing;
- Support to blood transfusion services to ensure security;
- Epidemiologic supervision;
- IEC activities to change behaviour by working through with community change agents;
- Equipment and functioning of services run by the National Program to Combat AIDS (PNLS).

A law on care for PLWHA was promulgated and a policy paper approved, which describes the standards and procedures to be followed (PNLS, 2004). The Strategic Framework to combat AIDS was then revised to include new strategies for 2006-2010, in particular:

- Prevention of Mother to Child Transmission (PMTCT);
- Paediatric care;
- Prevention among youths;
- Care for orphans and vulnerable children.

Promoting an *enabling environment for achieving the MDGs and thus the WFFC goals* included, inter alia:

- A community approach to local development based on a National Community Driven Development Program (PNDCC), implemented since 2005⁵;

³ Among other points affecting children, the Code fixes 18 years as the minimum age to practice commerce (§ 539).

⁴ Cooperation Agreement to Prevent, Suppress and Punish trafficking of Persons with emphasis on Women and Children.

⁵ The community approach has been promoted since the end of the 1980's by civil society organizations and gradually adopted by Government, for example in the Community Development Policy and then later in a National Community Development Program (PNDC) in 1998 with an attempt to set up the Community Development Units (UCD), in the Borgou Rural Development Support Project (PAMR) and in the approach adopted by the Social Fund, managed by AGEFIB until 2004.

- Decentralization with the empowerment of 77 local authorities (LAs) in early 2003 (MD, 2003), supported by several programs and projects⁶ ;
- The conformity of micro credit institutions (MCI) with the PARMEC law, the drafting of a National Microcredit Strategy aimed above all at providing support to informal economic activities and in April 2006, the creation of a public institution (with a Minister Delegate) in charge of Microcredit. These steps are expected to benefit small scale economic activities undertaken by women who are the most numerous borrowers and tend to use their income for the benefit of their children⁷ ;
- The budgetary reform, including the use of a results-based program-budget system.

3.- Tendencies in resource mobilization for children

General budgetary resources voted each year in the Law on Public Finances and allocated to the ministries in charge of health, education, child protection, combating HIV/AIDS and drinking water supply gradually increased and totalled just over a quarter of the overall national budget in 2006. Over the 2002-2006 period, the Ministry of Health Budget increased faster (8.5% per annum) than that of the Ministry of Primary and Secondary education (+ 2.3% per annum) while the budget of the ministries in charge of Justice and of the Family, Women and Children also increased slightly. Overall, even though the share of the overall budget of these ministries shrank slightly in 2002-2006, the total budget allocated to them increased by over 5% per annum, slightly faster than the population growth rate (3.25%).

Table 2: National Budget allocations to ministries in charge of social services (billion CFA Francs.)⁸

| | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 |
|-------------------|--------------------|---------------------|--------------------|-----------------------|------------------------|---------------------|
| National budget | 475.41 | 485.95 | 547.70 | 621.59* | 614.737* | 716.218 |
| MS | 38.328** (8.1%) | 39.43 ** (8.11%) | 45.67** (8.34%) | 46.855 ** (7.54%) | 53.117 (8.64%) | 57.666 (13.90%) |
| MEPS ⁹ | 77.59 (16.32%) | 81.99 (16.87%) | 71.18 (13%) | 79.597*** (12.81%) | 82.141***# (13.36%) | 93.886 (22.63%) |
| MFFE | 2.26 (0.48%) | 2.88 (0.59%) | 3.94 (0.72%) | 4.28 (0.69%) | 4.93*** (0.80%) | 4.396*** (0.61%) |
| MJ-CRI | 1.57 (0.33%) | 3.20 (0.66%) | 4.19 (0.77%) | 5.15 (0.83%) | | |
| MMEH | | | | | 19.87 ## (3.23%) | 29.058## (4.06%) |

⁶ The LAs are now responsible for building and maintaining maternal and primary schools, health centers at village/ward and neighbourhood levels, centres for social Promotion and youths, markets and slaughter houses. They are also in charge of provision and distribution of drinking water, maintaining hygiene and environmental sanitation as well as youth activities and assistance to destitute persons. (Law n° 97-029 of 15 January 1999 defining the organization of local authorities).

⁷ About 1 300 MCI serving 684 000 clients in 2005 which had collected 37.86 billion CFA Fr. of savings and lent 84 billion CFA Fr. to over 170 000 borrowers. In addition, an estimated 1 billion CFA Fr. is saved in the tontines and 9 billion with the more than 400 barefoot bankers (HELMS et al., 2005; DOVI, 2006).

⁸ Budget approved each year by the law on Public Finances. Sources: Health Statistics Yearbooks, MS; WB Report (2002) ; DANIDA (2004) ; *National Budget http://www.izf.net/izf/ee/pro/index_frameset.asp?url=http://www.izf.net/IZF/EE/pro/benin/3041.asp (Law on Public Finances 2006) ; **Health Statistics yearbooks (MS) 2005 ; 2006 and 2007 . ***MEPS/MFFE Budget (Management of Overall State Budget 2006-Expenditure sections 41 and 42). ; # 87 139 F with the Budget revisions ; ## DPP/MMEH.

⁹ Of which 8.99% for primary education in 2006 and 8.62% for the projection. 2007.

All resources of the MEPS are used for children but this is not the case with the other ministries. Actual amounts available for promoting a WFFC are not readily available as they are difficult to calculate or need to be based on estimates of the percentage of general services (for example, health services) consumed by children.

Between July 2000, when Benin became admissible for debt relief under the HIPC Initiative, and December 2004, the overall total of debt relief amounted 70.562 billion CFA Fr. of which 65.656 billion were available in 2001-2004, an average of 16.4 billion CFA Fr. per annum. Another 10.35 billion CFA Fr. of new grants were obtained during the same period, making a total of 75.9 billion CFA Fr. available in in 4 years.

Although some funds were not attributed, the most important sums attributed each year were for the health and education sectors: 82% of the total (63 billion CFA Fr.). The proportion varied from 67% in 2001 to 89% in 2003.

Table 3: Attribution of debt relief funds and grants, 2001-2004 (in thousands CFA Fr.)

| Ministries | 2001 | | 2002 | | 2003 | | 2004 | |
|------------|------------|----|------------|----|------------|----|------------|----|
| | Allocation | % | Allocation | % | Allocation | % | Allocation | % |
| MMEH | 1 916 129 | 10 | 1 735 000 | 8 | 1 317 153 | 7 | 1 751 739 | 10 |
| MSP | 8 657 349 | 48 | 8 625 762 | 40 | 9 429 289 | 48 | 5 784 436 | 35 |
| MEN | 3 494 600 | 19 | 9 294 000 | 44 | 8 356 794 | 42 | 9 070 835 | 54 |
| TOTAL | 18 166 078 | | 21 281 762 | | 19 724 236 | | 16 729 010 | |

Source : SIGFIP/MFE, 2005

However, in spite of an increase in the budget voted by Parliament each year, the spending capacity of the administration has remained low, especially in 2005 for the health and social sectors. Besides this, the National wealth increased more slowly than was hoped, following a slowing down of the economy as from 2001.

Table 4: Economic growth rate (GDP)

| 2001 | 2002 | 2003 | 2004 | 2005 | 2006 (est.) |
|------|------|------|------|------|-------------|
| 6.2% | 4.4% | 3.9% | 2.7% | 2.9% | 4.5% |

Source: INSAE (Monitoring tables 2000-2003); OCS (Social profile)

4.- Design and use of tools used to monitor WFFC/MDG s

The situation before the decision to launch a World Fit for Children (WFFC)

Several documents either specifically describe or provide pertinent information on children's situation as it was prior to 2003, in particular:

- A report of the workshop on a vision of the Benin child in the 21st Century (BENIN-UNICEF, 1999);
- The Benin National Report on the End of the Decade Review to monitor the goals of the World Summit for Children (MECCAG-PDPE, 2000);
- The Demographic and Health Survey (DHS) in 2001 (INSAE-ORC MACRO, 2002) ;
- The Benin Poverty Assessment (World Bank, 2003);
- The Third General Census of Population and Housing (RGPH3) in 2002 (INSAE, 2003);
- The 2nd Periodical Report on the implementation of the CRC covering the period up to 2002 (MJLDH/DDH).

Monitoring of MDGs

A dual national process monitors progress towards the WFFC and the MDGs targets. They are: specific reports on the MDGs; a mechanism to monitor the PRSP-I.

The first report on the MDGs in 2003 was produced under the aegis of the National Statistics Council (CNS) with support from the UN system (based on BenInfo data).

Two further reports were published by the Observatory of Social Change (OCS)¹⁰. These are:

- The report on the MDGs (2000 + 5), which provides national data up to 2004 in certain fields. The report indicates those activities which contributed to progress towards the MDGs and, for each goal, identifies the principal challenges facing the country.
- The report by department in 2006, containing data for 2002-2004 on the eight MDGs in each of the six ancient departments as well as for the whole country. The analysis estimates the possibility of achieving each MDGs in each department.

The monitoring is based on figures from the regular statistical system, the poverty surveys undertaken in 1994-95 and 1999-2000, the CWIQ, the results of DHS 2001 and the Third Census count (2002).

Monitoring of the MDGs is also undertaken by civil society: a first alternative report was validated in September 2005 (Social Watch-Benin, 2005). This report contains information on the period up to the publication date and emphasizes the qualitative aspects of the on-going development process.

Monitoring of the PRSP-I is undertaken on two levels. The first is a report on the financial execution, as part of the reform of public finances, undertaken with support from the World Bank through an Adjustment credit (PERAC). The second monitors the efficiency of activities and their impact. This second aspect is followed up by the Permanent Secretariat of the CNDLP, set up at the same time as the OCS and also attached to the MDEF.

Indicators of most targets related to MDGs 1 to 7 are part of the PRSP-I monitoring mechanism. Progress reports based on the regional reports are approved and published each year¹¹. These reports provide information on several essential WFFC aspects although the 3rd priority area (protection) is scarcely dealt with in the 2005 report.

Regular surveys include the Census Count, the DHS (2001) and the poverty surveys. A specific volume of the Census Report studies the situation of vulnerable persons (children, women, handicapped persons and elderly persons). Figures by department are available on the number of children in school, the level of studies reached, whether children aged 6 years old and more are employed or not, as well as access to drinking water and toilettes and housing conditions. One particular chapter provides 2 maps showing the spatial distribution of non-monetary poverty and a proxy for the Human Poverty Index (HPI). Later work by the INSAE presents a map of non monetary poverty by neighbourhood (Arrondissement). A booklet on Socio-demographic indicators gives the level for those indicators collected by the Census which are pertinent for the MDGs.

Other studies underway are: the National Integrated Modular Survey on household living conditions (EMICOV) and the 3rd DHS which follows those in 1996 and 2001 and should make the provisional results available in early 2007. A joint INSAE-UNICEF study compares a series of social indicators between households classified by their degree of poverty/prosperity. (IMR, U5MR, MMR, fecundity, access to health services (especially

¹⁰ An organism proposed in the PRSP-I and set up jointly in 2004 by the Ministers in charge of the Plan (MCPPD) and the Economy (MFE), and now integrated into the Ministry of Development, Economy and Finances, and in charge of monitoring the MDGs and the PRSP.

¹¹ The monitoring and implementation mechanism of the PRSP in 2003-2005 produced progress reports in February 2005 for 2004; in September 2005 for 2004 and September 2006 for 2005. The Permanent secretariat of the CNDLP prepares the validation meetings in each department, presided by the Prefect; and informs both a General meeting of the CNDLP and an Interministerial Committee of the state of affairs, before the reports are approved. The departmental monitoring committees (CDS) were set up in early 2004, but their working capacity remains to be seen.

antenatal visits and assisted delivery) as well as access to primary education (VODOUNOU et al., 2003).

A **CWIC Survey** (Core Welfare Indicator Questionnaire) was undertaken with support from the World Bank in 2002 which enable poverty maps to be drawn up showing the spatial pattern of poverty.

A **Social “Instrument Panel”** presents the baseline data on the socio-economic situation in 2000-2003. Drawn up by the INSAE with support from the OCS, the renewed structure of contents follows the pattern of the MDGs and emphasizes the indicators used in monitoring the PRSP-I (INSAE, 2005).

Beside this, the Social Profile covering 2000-2004 was published by the OCS (2006) with information on activities related to poverty reduction, including the HIPC initiative and the budgetary allocations of debt relief funds as well as the contribution of those funds to changes in indicators of social welfare (education, health, drinking water, rural roads).

Two “alternative reports” were drawn up by civil society for the United Nations Commissions presenting its point of view on children’s rights (CLOSE, 2006) and on children in the legal system (OMCT., 2005).

The national socio-economic database (including data on monitoring of the MDGs and the objectives of the PSRP-I), called **BENINFO (Devinfo version)** is managed by the INSAE with support from the United Nations since 2002. Three other observatories were set up: the **Observatory of the Family, Women and Children** by the MFFE in 2005, with support from UNFPA and UNICEF; **the National Urban Observatory in the MDCULRF-LCEC**; the **Observatory on protecting children against trafficking and exploitation in work**. The latter has a joint public-private status and was set up by the Benin Association for Aid to Children and the Family (ABAEF) with support from ILO-IPEC. A community based mechanism for monitoring child trafficking is being set up by the MFFE with support from UNICEF and USAID.

A National Commission on Children’s Rights with its departmental branches was set up in 2002.

5 Improving partnerships and alliances for children and children’s participation

Several types of partnerships and alliances have been developed since 2002:

- *Public-public* partnerships between *State structures and external technical and financial partners* in many different fields. These have been particularly important for debt relief, following partner by partner negotiations with 9 funding agencies and 6 international organizations¹². There are also some specifically targeted operations (WFP-UNICEF to provide food for children in conflict with the law...) as well as a considerable increase in funds from certain donors for specific areas of activity, for instance for rural water supply (DANIDA, GTZ, Belgium, Holland, European Union, WB...), education (UNICEF, Holland...) or protection of children (UNICEF, EU, DANIDA in the Zou...) and Human rights issues (DANIDA). New partnerships were also developed in various areas of health care, in particular for EPI, Combating malaria and Maternal health with regular coordination meetings.
- *Between different Government structures*, with several interministerial organizations being set up in areas related to the MDGs (with support from UNDP) and WFFC: the CNDLP and its components, the strengthening of the National Committee and National

¹² Canada, China, France, FRG, Holland, Italy, Japan, Norway, United Kingdom ; AID, EIB, BOAD, ADF, IFAD, IMF.

Program to combat HIV/AIDS (CNLS and PNLs), the National Commission on Debts, the National Commission on Children's Rights and its departmental components.

- *Between the State and civil society organizations* and gradually also *between LAs and civil society organizations*. An institutional innovation is the creation by ministerial order in early 2006 of the National Monitoring and Coordinating Unit on Child Protection, with a role of combating child trafficking; the Observatory for protecting children against trafficking and exploitation in work; the National Institute and the National Fund to support Literacy Training and Adult Education; the Water Partnership which promotes integrated water resource management (IWRM); the Steering Committee of the national representation of the Regional Low Cost Water and Sanitation Centre (CREPA) in Benin.
- *Between civil society organizations* to undertake work in several different LAs (CARE's PROCHILD program with 22 national NGOs in 9 LAs; Social Watch with a Focal Point in Benin run by the NGO United Sisters at Work (SUO) and regrouping 17 NGOs and networks; the Liaison Committee of social organizations defending children's rights [CLOSE] with some 30 NGO members; the Network of organizations protecting children in difficult circumstances [RESPESD] with 20 member organizations; the Platform of Civil Society Actors in Benin [PASCIB]).
- Joint partnerships between *State structures, private companies, civil and external technical and financial partners* which is particularly innovative and has allowed considerable progress in the two major areas of: (i) implementing the PMTCT in maternity homes and (ii) combating child trafficking¹³.
- *Partnerships with and between LAs, communities and civil society* to strengthen local capacity and undertake local development activities, which include: Local Authorities-State-Donors (PRODECOM...); LAs-civil society (SNV...); LAs-communities-State-Donors (CNDCC); communities –civil society (CBDIBA, Aide and action, AFJB and many other NGOs).

As far as *children's participation* is concerned, this can be seen, inter alia, in the activities of the association of child and youth workers (AEJT), children's groups supported by different NGOs and Government services and the sessions of the Second Legislature of the Children's Parliament. The Association of members of parliament (MPs) Friends' of Children has taken steps to obtain legal recognition of the Children's Parliament.

6 Implementing the WFFC Plan of Action and the targets of the relevant MDGs

Implementing the MDGs which are specifically linked to each of the four WFFC priority areas of action seems to be on track in relation to 1900 levels for the reduction of underweight children, access to clean drinking water and eventually for universal primary education¹⁴ (see Annex: Table 1). This evaluation is confirmed by the OCS (2006) on the basis of analyses by department as well as estimations made by other partners (cf. Annex: Table 2). However, the figures for chronic malnutrition (height for age), which increased over the 1996-2001 period, do not confirm the positive interpretation of the drop in the ratio of underweight children. As for universal primary education for all children, it may well be thwarted because of the gaps between regions, the girls-boys gap and the low level of achievement in primary school, especially for girls (37%). If the MDGs which are specifically linked to a priority area of action are not met, then the WFFC achievement in this field will not be possible (cf. Table 1, § 2).

¹³ FENAB, Foreign and National NGOs, French and Swiss Cooperation, Government, ILO, Local Authorities, UNICEF,

¹⁴ Chronic malnutrition levels.

Although there are reserves on reaching the MDGs, a considerable number of pertinent activities were undertaken between 2003 and 2006, which could be appreciated by the numerous indicators of the WFFC overall Plan of Action (see Annex 2, Table 4). Political will has been made clearer (free preschool and primary schooling, better targeting of MDGs in the PRSP-II...) and, together with the decisions taken to inaugurate new policies, strategies and overall programs, are positive steps which indicate a real will to build a WFFC. Concern for children's situation is also clearly shown in the periodical report submitted by Government to the UN committee on the rights of the child and the alternative report drawn up by civil society.

6.1. Promoting healthy lives

Although the indicators of *infant and under 5 mortality* have dropped, they still remain high: 89‰ of children less than one year old for 1 000 live births and 160‰ for under 5 year olds in 2001 (DHS). In addition, the U5MR is higher in rural areas (+ 13 points) and even higher for poorer (+ 26 points) for children from the 20% poorest households (VODOUNOU et al., 2003). To reach the MDG 4 in 2015, it will mean reducing the U5MR by 5.92 percentage points each year as compared to the recorded drop of 0.86 percentage points between 1996 and 2001¹⁵.

One of three major problems is the high level of neonatal mortality (38‰) which has not changed for more than a decade and constitutes nearly 40% of all children's' deaths before the first birthday. Of these deaths, some ¾ occur during the first week of a child's life. This high mortality is closely linked to maternal health conditions (pregnant women's nutritional status, access to quality antenatal care, properly assisted delivery, response to obstetrical emergencies, postnatal care, use of contraceptives¹⁶...). Presently, 7 out of 10 women give birth in a maternity home and 9 out of 10 attend antenatal visits (MS, 2006), but they tend to consult late while access is far lower (- 16.6 points) for women from the 20% poorest households (VODOUNOU et al., 2003)¹⁷.

The maternal mortality ratio has also remained stagnant at nearly 500 per 100.000 live births for over a decade (DHS 2001, RGPH3 2002)¹⁸. The lack of trained personnel, delays in transferring emergency obstetrical cases to a reference hospital, and the cost of operations are the main causes.

The Government and the international community are taking into consideration the life-saving neonatal and infant interventions published in the scientific journal « The Lancet » which has led to several readjustments of the strategies targeting child survival. The Government has shown strong commitment to the Syrte Declaration signed by the African Heads of State in July 2006 and is presently building up a partnership around a common survival strategy for pregnant mothers, newborns and children which is based on the use of a minimum package of cost effective, life saving activities¹⁹. Their effective implementation, presently being generalized, gives new hopes of reaching the MDG 4.

A second major problem are the three main reported illnesses: malaria, acute respiratory infections and diarrhoeas, which are the cause of 60% of children's consultations. **Frequent and recurrent malaria** (41% of all cases) remains a major public health problem²⁰ with an

¹⁵ Source: Evolution of rates between 1996 and 2001.(DHS).

¹⁶ Modern contraceptive use remains low (7%) but is increasing quickly, especially in urban areas, in the South and in Borgou department thanks to activities in public health centres and the Association Béninoise pour la Promotion de la Famille (ABPF).

¹⁷ 64.6% for the anti natal consultations; 44.6% for assisted births.

¹⁸ The United Nations estimates the rate as being 850 per 100 000 live births, as it takes account of the sample size and the identification of the real causes of death of many women

¹⁹ EPI +, IMCI + and MNNC + (maternal and neonatal care).

²⁰ Malaria is an important cause of school absences and can lead to neurological complications which will prevent a child from working well in school. For pregnant women, malaria makes anemia even worse and is one cause of low birth weight.

overall incidence of 113 per thousand among the general population and 397 per thousand among children under one year old, although these figures do not indicate the real frequency which is over 10 times higher (LANGLEY et al., 2006), as more than 60% of the population do not attend health centres for curative consultations²¹. Malaria is the major cause of death among under 5 year olds (23% of all deaths of under fives in Africa).

Confronted with this problem, Benin has joined the *Roll Back Malaria* initiative and has made considerable efforts in this field, setting up a National Program to Combat Malaria (PNLP) within the Ministry of Health with the status of a Direction. The emphasis is on preventive work, especially the distribution and use of treated bednets for women and under fives²². A new initiative is now being generalized in all public health centers which are to provide all women attending prenatal consultations with an antenatal kit (comprising a treated bednet, iron, folic acid and an anti-parasite medicine) as well as preventive intermittent treatment of pregnant women against malaria. A strategy for survival of the mother, the newborn and the child, newly adopted by the ministry of health, includes an important component on combating malaria. An operational research on intermittent preventive treatment of nurslings against malaria is under way in 2 health districts. Several partners support the Government in this effort (UNICEF, USAID...). An annual national telethon has been launched to collect funds to buy bednets for the PNL. The World Bank will finance a Booster Program to provide treated bednets for all under 5 year olds in Benin in 2007 and Benin has now been eligible to the USA's presidential program to combat malaria.

Curative treatment of ordinary malaria is to prescribe « Artémether-Luméfantine » instead of chloroquine²³.

The nutritional situation is particularly preoccupying and constitutes a third major public health problem in Benin: in 2001, it was estimated that 46% of deaths among under 5 year old children were linked to malnutrition. Anaemia among women and children is extremely prevalent²⁴ and contributes to the death of the latter. Stunting of children aged from 0 to 36 months is an indicator of chronic malnutrition, and has slightly increased from 25% in 1996 to 27% in 2001 (DHS). For children aged from 6 to 59 months, it reached 38.6% of all children in the country in 2001 and 49.5% in one health district in the North West of the Country in 2005. The level of stunting of children from the 20% poorest households was 1.9 times higher than that for children of the same age from the most prosperous households (VODOUNOU et al., 2003). There is no national program to undertake growth monitoring and advice parents what measures to take when malnutrition is present. Nor is there a national protocol for care of malnutrition in health centres, which means that malnutrition is not always detected and that malnourished children are not always identified; even when they are, do not necessarily receive adequate treatment. There is neither coordination nor adequate collaboration between the different actors. In spite of some shortcomings (no use of the growth chart and distribution of food to mothers of children who are not undernourished), the Community based Food and Nutritional program provided some response and the MFFE is now actively researching a new partner. Besides this, a new food security program through agricultural intensification (PSAIA) is being set up with financial support from the ADB and the Government.

²¹ 37% in 2005 including the major private centers (MS/DPP, august 2006). A study in a Health District in North West Benin (Tanguéta-Materi-Cobly), where 50% of the population attend health centres, identified the causes of non attendance as: lack of qualified health personnel; lack of some services in front-line centers; poor welcome for clients; lack of certain drugs (sometimes deliberate), lack of family resources, difficult access and some religious practices (KPATCHAVI, 2006).

²² The important drop in the cost of impregnated bednets considerably increased the demand and 41% of under 5s are now reported to sleep with a treated bednet (PLNP National Survey, 2006) as compared to 5% in 2001. Use of treated bednets through community activities has been effective as 8 out of 10 mothers now say that malaria is transmitted by mosquito bites.

²³ An anti malarial drug based on traditional plant medicine will soon be made and packaged in the laboratory of the departmental hospital in Porto-Novo, the capital.

²⁴ 82% (under 5 children), 64% (women aged 15-49 years) and 73% (pregnant women).

In addition, Benin committed itself to total iodization of salt in October 2004, together with several other countries in the region.

On an international level, the « Standing Committee on Nutrition » (SCN) drew the countries' attention in 2005 to the critical role of nutrition in reaching the MDGs. This implies particularly: MDG 1 [Eradicate extreme poverty and hunger]; MDG 2 [Achieve universal primary education]; MDG 4 [Reduce child mortality]; MDG 5 [Improve maternal health].

On the contrary, **vaccination** coverage of all antigens has been maintained at over 80% since 2000 (except for a slight drop in the measles' vaccination level in 2005) and has reached 94% for DPT3 and 111% for BCG. This meant in 2001 that 59% of all children from 12-23 months old were completely vaccinated against all six illnesses as compared to 56% in 1996. This is the highest average rate in all Sub-Saharan Africa. Since 2005, the routine vaccination program has been extended to 9 antigens with the introduction of Pentavalent, a combined vaccine which reduces the number of shots and thus makes it easier for women to bring their children (less visits to make, etc.) and the introduction of an anti-amaril vaccine. Benin's adhesion to the Vaccine Independence Initiative led to the country being able to pay for all traditional vaccines itself (tetanus, measles, BCG, DPT, Polio) together with the consumable products for the EPI from 2001 up to 2005. From then on, with the free supply of Pentavalent vaccine by the GAVI as part of injection security, Benin has not purchased DPT, hepatitis B and anti-amaril vaccines or SAB (self blocking syringes). As from 2008, Benin will assume the financial relay of pentavalent as well as the SAB. Linked to vaccination, the distribution of vitamin A by children has remained reasonably high, in spite of a drop from 94% in December 2005 to 76% in May 2006.

In the field of **safe drinking water**, considerable progress has been made, especially in rural areas, thanks to Government funds and important external support as well as contributions from various actors and decentralization (transferring some responsibilities to the LAs) and devolvement within the ministry in conformity with the national strategy which was revised in 2005 (MMEH/DGH, 2005). The annual rate of infrastructure provided has more than doubled to reach 1 000 equivalent water points/year²⁵ since 2004 with a perspective of reaching 1 500 equivalent-points/year, as compared to the 1 350 equivalent-points/year needed to reach the MDG 7 target on access to clean drinking water but also to the eradication of Guinea worm²⁶.

In the field of **basic sanitation**, the situation has somewhat improved with some 32% of the population having access to toilettes or improved latrines, but the level is still extremely low. The National Hygiene and Basic Sanitation Program (2004-2008) needs large-scale support in order to make improvements, as well as the hygiene and sanitation components in all the water supply projects. In particular, this will need large scale communication activities aimed at behavioural change. Emphasis would be on hand-washing as this will considerably reduce infections from faecal matter. Important efforts will therefore be made by the Government, which will seek support from partners in order to implement this program which should give rise to an important increase in the level of the sub-sector indicators.

6.2. Providing quality education

Progress in schooling levels continued in 2002-2003, but both the net and gross ratios went down slightly in 2003-2004 and 2004-2005, following a series of teacher strikes.

Table 5: Evolution of Gross and Net Schooling rates in 2003-2005

| School | Gross schooling ratio (GSR.) | Net schooling ratio (NSR) |
|--------|------------------------------|---------------------------|
|--------|------------------------------|---------------------------|

²⁵ An equivalent water point = 1 bore hole with hand/foot pump ; 1 public water fountain with 2 taps, 1 large diameter well = 2 equivalent-points.

²⁶ Certification is expected in 2008.

| year | Boys | Girls | Total | Gap | Parity index | Boys | Girls | Total | Gap | Parity index |
|---------|---------|--------|--------|-------|--------------|--------|--------|--------|-------|--------------|
| 2002-03 | 114.30% | 82.30% | 98.30% | 32 | 0.72 | 96.69% | 70.51% | 83.60% | 26.18 | 0.73 |
| 2003-04 | 108.00% | 84.26% | 96.38% | 23.74 | 0.78 | 89.83% | 70.89% | 80.56% | 18.94 | 0.79 |
| 2004-05 | 105.22% | 84.09% | 94.84% | 21.13 | 0.80 | 84.95% | 68.87% | 77.05% | 16.08 | 0.81 |

Source: School statistics

The gap between boys and girls schooling ratios continued in 2005, as well as the regional gaps, with gross schooling rates for girls being lower than the national average in 43 of the 77 LAs. Nevertheless, the gap is targeted by specific programs and is being gradually reduced, 32 points difference in 2002-2003 to 21 points in 2004-2005 for the gross schooling rate. The gross schooling rate became higher for girls in one LA area in 2001-2002, thanks largely to local leadership and effective community involvement; it then became higher in another LA in 2003-2004 and in yet 3 others in 2004-2005, although a slight drop in boys schooling has been noted at the same time.

Although the gross admission rate in grade 1 improved, rising to 94% in 2001-2002 and reaching 100% in 2004-2005, it is estimated that only about half of all children who start primary school will finish the 6 grades (62% for boys; 37% for girls in 2003-2004), because of the persistently high repeater levels (16.95% in 2004-2005 with a one point advance for boys) and drop out rates (13.28% for boys and 14.8% for girls). The results is that more than one girl in three aged 6-11 years old is not in school and nearly one boy in four.

Besides the strikes, which discourage parents, the low performance level is closely linked to deficiencies in the schooling system which were already identified during the National Education Forum in 1990: insufficient infrastructures and teachers (pupil/teacher ratio: 53,2 in 2003-2004), high proportion of unqualified teachers (about 50%), weak pedagogic follow up and supervision; low levels of distribution of school books; parents poverty which limits the purchase of the “Activity Notebooks” and other school needs. In addition, although the network of schools provides a reasonable level of access, in isolated areas there are still communities where the school is under-standard or where there is no school.

Major changes in Government policies

The Education for All Plan defined the educational strategies for children most difficult to reach, by proposing educational alternatives. The Educational Policy Paper and the Ten Year Plan which it inspired included the Essential Educational Package for girls schooling (PEE) as one of the main strategies to achieve gender parity as part of universal primary education in 2015. The pre-school strategy (3-5 years) of providing Government support for community and NGO initiatives is included in the Ten-Year Plan. A national strategy on how to provide this support to community initiatives is now being drawn up.²⁷

In addition, the Government adopted an inter-ministerial order punishing violence and sexual abuse in schools (2003) which was followed in 2006 by a law on sexual harassment.

After having abolished school fees for girls in rural areas in 1993 and for all children in 2000, the Government took over the cost of salaries for community recruited teachers as from the 2004-2005 school year²⁸. Even though some teachers are still recruited and paid by communities, the cost for parents is considerably reduced which encourages sending children to school and keeping them there, especially the girls who are often left out when parents have to make difficult choices because of a tight household budget. In October 2006, a Government decision went a step further and abolished all school contributions which parents had to pay for pre-school and primary schools.

²⁷ “Childrens spaces” were set up, for instance, by Aid and Action and later on, in the Educom program run by MEPS with support from UNICEF.

²⁸ Previously paid by parents contributions, their salary was usually lower than the official minimum wage (between 12 000 CFA FR. and 20 000 CFA FR. per month).

In addition, as part of the decentralization process, 76 of the 77 LAs drew up their Economic and Social Development Plan in which education was generally one of the priorities as the LAs are now responsible for building and maintaining pre-school and primary schools.

For children over school age or who dropped out, non-formal education is a solution tested since 2001 through joint work with apprentices in 6 towns by the MFFE and NGOs.

On an *institutional level*, new technical services have been set up by the Government in the MEPS in order to provide adequate support for the efforts being made to reach MDGs 3 and 4:

- The Direction to Promote Schooling (2004), with one of its principal services being in charge promoting girls schooling. Other services undertake work aimed at improving the quality of the educational offer and youths' apprenticeship in particular through sports, and including education in the combat against HIV/AIDS;
- The Direction of Maternal Schooling (2004), which shows that there has been a raising of political awareness of the importance of preschooling in an integrated approach to children's development;
- The Direction of Pedagogical Inspection (2005), which will counter weaknesses in this field;
- The Direction of Educational Decentralization and Cooperation (2006) which shows the MEPS determination to harmonize its approach with the overall decentralization process, aimed at making LAs more responsible in educational matters.

6.3. Protecting against abuse, exploitation and violence

Economic exploitation and child trafficking are major issues which involve civil society, the authorities and their partners. Endemic poverty, low literacy levels and in certain social groups, low schooling levels and an unsatisfactory teaching quality and even food insecurity in certain cases as well as the lack of economic opportunities for youths all contribute to creating an environment in which the phenomenon will be perpetuated.

A total of 480 000 children from 6 to 14 years old are classified as «occupied»²⁹ in 2002, which is more than a quarter (27,5%) of the age-set, of whom many are young girls working as *Vidomégon*³⁰. In 2006, out of a total population of about 1.5 million children aged 10 to 17 years old, 700 000 (45%) were not in school (OBURA, 2006). About 50 000 other children had migrated and were working in other countries (OUENSAVI and KIELLAND, 2000).

However, lack of information in these areas makes an adequate problem analysis rather difficult. Similarly, the evolution of the number of children involved in trafficking is not known, nor how they are recruited; the paths they follow and the way they travel, especially as concerns trafficking with other countries. Children's profiles, their areas of work, the employers who request child labour and the working conditions need to be better known. All this information would contribute to a better causal analysis of the phenomenon and the factors which have led to a development of trafficking as well as the impact on children. Studies undertaken by Terre des hommes (TdH) and the ILO (OIT-IPEC, 2001) have provided information on certain departure and arrival zones but have not allowed an overall

²⁹ Occupied person: person who had worked for at least one week, whether continually or not, in the 3 months preceding the Census.

³⁰ Traditional practice of poorer households to confide their child (*vidomégon*) to a better off family, usually living in an urban area, in order to give him a better chance in life. A widespread tradition which usually included on the job training in a trade or sending the child to school in exchange for the child's help in the home. This tradition has been corrupted and the practice has become a means of recruiting and exploiting children as domestic servants and even a form of child trafficking.

understanding of the phenomenon on a national level³¹. So that the dynamics of the trafficking system can be better understood in Benin, a national study has been launched by the MFFE with support from UNICEF.

In spite of this lack of information, important progress has been achieved in the area of combating trafficking in the last few years. The situation became more obvious to the public in 2003, when 260 children were repatriated to Benin from the stone quarries in Abeokuta (Nigeria) where they had been working and were reinserted in their home settings. Different social actor's awareness of the phenomenon was sharpened and these actors realized more clearly the need to strengthen field activities. 1 450 local committees to combat child trafficking were set up and 40% of them trained in planning their activities. A network of 9 centers which protect, listen to and counsel children, set up in 6 towns by the Government and NGOs with support from UNICEF³², took care of more than 3 000 children and reinserted over 2 500 of them. In the Zou department, the main children's departure zone, Community Action for Children's Protection (ACPE) involving LA councillors and other local actors, was launched in October 2006 by two NGOs (World Learning and GRAPAD), thanks to financial support from the US State Department.

The strongly felt need to exchange information and set up coherent responses, to harmonize procedures, improve coordination and profit from synergy between actors led to the setting up of a National Coordination Unit on Child Protection with 4 technical working groups (Trafficking and Exploitation, Youth Justice, Violence on Children, Orphans and Vulnerable Children) under the aegis of the MFFE³³. Agreements were also signed with neighbouring countries to coordinate activities in combating the phenomenon.

Considered a few years ago as one of the countries in the region most affected by trafficking, Benin has improved its position in the USA's country classification on trafficking thanks to Government and partners efforts, having moved from level 3 in 2005 to level 2 in 2006³⁴ (USA STATE DEPT, 2006).

The situation in relation to *youth justice* remains preoccupying. Only 2 of the 8 jurisdictions have a judge qualified for the Children's Court. An estimated 400-500 children go through the prison system each year, and the length of preventive detention does not always follow the regulations while the judicial follow up is insufficient³⁵. Most parents are too poor to follow up the case properly. Neither the officers of the Criminal Investigation Department nor the personnel taking care of these children have the knowledge needed to deal adequately with minors in the framework of a judicial system.

The Government does not have enough financial and material resources to undertake preventive activities, nor protection or effective care of children in conflict with the law. Besides this, although a sum of 850 million CFA Fr. was allocated for penitentiary assistance in the 2005 national budget (without distinction between adults and children in conflict with law), only 15.5% was actually spent³⁶.

³¹ The ILO-IPEC-LUTRENA has also undertaken a study on paths followed by children being trafficked. Another ILO-IPEC-LUTRENA study on child trafficking with a view to labor exploitation in Benin is presently being finalised.

³² NGO members of RESPESD run several "listening and orientation" centers.

³³ The Unit was set up after pressure from the actors, following the National Workshop on Coordination of the Combat against Child Trafficking, held in Porto-Novo in November 2002 which was attended by 4 ministries (MFFE, MAEIA, MISD, MJLDH), 6 civil society organisations, the project to strengthen the Juvenile Brigade and the 3 partners most involved (UNICEF, EU, DANIDA).

³⁴ Level 3: countries having made no progress against child trafficking and exploitation; Level 2: Countries having undertaken some actions to combat child trafficking.

³⁵ All prisons are over populated (1 810 places for 4 336 prisoners) and minors wards exist in 7 of the 8 prisons. In Parakou, where there is no minors ward, some children are sent to a religious center where they are supervised by trained personnel. In Cotonou prison, the minors can easily mix with adult prisoners. During a visit in June 2006, there were 55 children and youths aged from 12 to 18 years old in preventive detention, up to 4 years for one child. Living conditions are at risk: lack of space (20 beds in a 20m² dormitory and a courtyard 20mx30m), deplorable hygiene (1 shower, 1 latrine, hardly any soap), no health care. A social worker visits the prison once a week. After the civil societies' alternative report on Human Rights (OMCT, 2005), the NGO Forum for Prison Reform (Amnesty International, Dimension social, ACAT, LDH, ODIP) made a public appeal in November 2006 to relieve prison overcrowding and improve detention conditions.

³⁶ Source: MJ-CRI.

UNICEF, PAM, and the NGOs «Fraternité des prisons» and «Prisoners without Borders», provide financial, technical and material support in this field. Most children do not receive psychosocial care, which is not yet a priority.

Significant efforts were made by Benin in 2006 to conform to its international commitments in this field. Presently, children are rarely kept in preventive detention longer than the reglementary 72 hours, following an intervention from the public prosecutor.

In order to improve the penal system for minors, and conform to international instruments, the Government has drawn up a plan of action which will identify and implement alternative measures for children in conflict with the law. These measures will lead to rehabilitation, strengthen their reintegration in the community and prevent further offences. The Government Order on infractions committed by adolescents of July 1969 has been amended and included in the proposed Children's Code. In addition, two new centers for juvenile delinquents have started their operations in the North and the South West areas of the country which means that, together with center already operational in the Cotonou agglomeration, each of the 3 Appeal Courts now has a center available.

Violence against children persists: ill-treatment in home and at school, female genital mutilations (FGM), infanticide, sexual violence, etc. An estimated 95 % of children working as domestic aids (*vidomégon*: mainly girls) suffer from ill-treatment. Sexual violence within the family is not really discussed, as is the case in other countries, especially if it is incestuous. Yet numerous testimonies show that children, mostly young girls, are victims of sexual violence in the family environment. Awareness of these problems has increased at community level where violent acts and ill-treatment are increasingly denounced.

In the field of female genital mutilations (FGM), about 17% women were excised, $\frac{3}{4}$ of them before their tenth birthday, according to data from the network of listening centers, which is similar to the results of the 2001 DHS. However, the practice is declining as only 12% of 15-19 year old women were excised in 2001. The law enacted in 2003 suppressing and punishing FGM was voted following advocacy by the NGOs, the MFFE and MS, UNICEF, UNFPA and the group of MPs friends of children. 500 community workers were trained in popularisation of the law which forbids excision and all similar practices and thus contributes to the protection of children against harmful traditional practices.

In this field, as elsewhere, Government policy is through prevention and protection for women and children, as is shown in the various laws enacted (cf. § 2).

Birth registration is not yet satisfactory. The aim is to reach 80% registration rapidly as compared to 69.7% in 2001 for under five years old children. Some activities, including those sponsored by UNICEF, PLAN-Benin and several other NGOs, in some cases in close cooperation with the LAs have already led to 15,000 children benefitting from a birth certificate after having received a supplementary court judgement; this allows them to sit the primary school leaving certificate and above all, protects their legal status. A large scale action is already under way since September 2006 which will enable 15-17 year olds to obtain a birth certificate free of charge: the Phase 2 of the Administrative Census for Population Registration (RAVEC), which started with the external court hearings. A further phase is envisaged which would deliver a birth certificate to under fifteens.

Besides the National Coordination Unit for Child Protection with its 4 technical working groups, **the administrative framework** was strengthened by the extension of the network of legal consultancy centers which provide advice to poor people and work in cooperation with the «barefoot jurists»³⁷.

³⁷ The origin of this program is the realisation that so-called "lawyers friends" were cheating women who were trying to solve legal problems. In order to make information on citizens rights and duties available closer to women, 128 «barefoot lawyers», voluntary community workers with 4^{ème} grade secondary school level, were trained in 8 classes. The program was set up and is run by the NGO CBDIDA and presently

6.4. Combating HIV/AIDS

Unprotected sexual relations are the principal transmission path of HIV/AIDS in Benin. The prevalence is 2% in 2005, although there are important regional differences. The National Framework to Combat HIV/AIDS (2001-2005) was implemented with partner support and was coordinated by the CNLS. A new Strategic Framework, approved for the 2006-2010 period, proposes a stronger CNLS so that it can play a more efficient leadership role. The new framework includes the PMTCT, paediatric care, prevention of transmission to youths and support for orphans and vulnerable children (OVC).

Out of an estimated 13,000 infected persons needing ARVs, less than 40% receive treatment (including 150 children). Some 2 400 infected children are born each year by 7 200 infected mothers (1/3 of children of infected mothers) because appropriate treatment is not available everywhere. About 34 000 under 18s are orphans because of HIV/AIDS, having lost either their mother or their father.

This situation is changing: in December 2005, the ministries of Health, and Foreign Affairs, the CNLS, ONUSIDA and UNICEF launched a campaign “Unite for children – Unite against HIV/AIDS”, with 4 major themes:

Prevention of Mother-to-Child transmission (PMTCT), started in 2000 with 33 maternity homes now covers 185 homes (39% of all public and private maternity homes). The PMTCT is already an integral component of standard practices in those maternal services, with 9 out of 10 women accepting voluntary testing. In July 2006, agreement was reached in Benin on feeding recommendations for infected children; training on this subject is under way and although this could be improved, it is an encouraging step. A *National Guide on Nutritional Care for PLWHA* has also been followed by training; the guide will be published and distributed as well as a booklet for PLWHA.

Paediatric care: Some 150 infected children are presently receiving ARV in two health centers in Cotonou (CNHU and the Army Hospital) and the Departmental Hospitals in the Capital (Porto Novo) and two other towns (Abomey, Parakou). Efforts are underway to increase access to paediatric treatment for more children in cooperation with UNICEF. Early diagnosis and paediatric versions of ARV drugs are also included in the strategy, but are not yet operational.

Protection and support to children affected by HIV/AIDS (OVC): of the 342 000 orphans and vulnerable children under 18 years old (8.4% of the age-set), an estimated 10% are affected by the HIV/AIDS. The OVC program has been part of the national agenda since 2004. An agreement signed between the principal partners led to a situation analysis in 2005 and a Plan of Action 2006-2010 which offers protection, care and support for OVC, which was approved in July 2006. Application has started with 1 450 OVC receiving a minimum package of services put together in 2006. In addition, community solutions for care of orphans are encouraged by the MFFE.

Preventing infection among youths: the law n° 2003-04 of 3 March 2003 on Sexual Health and Reproduction institutes the right to information and care in reproduction health matters for youths and children without requiring parental consent and banning discrimination based on sex, age or ability to pay; it also provides for special assistance for persons with a STI or HIV/AIDS. The law was followed by a policy document determining standards and procedures for the care and treatment of PLWHA.

financed by DANIDA. It also includes 6 law « clinics » providing advisory services in smaller towns (Allada, Bohicon, Dogbo, Natitingou, Parakou, Savé). Three other clinics (Abomey-Calavi, Lokossa et Porto-Novo) are run by the AFJB.

The law n° 2005-31 on prevention, care and control of HIV/AIDS, enacted in April 2006, institutes the right to prevention, detection and treatment as well as protection against discrimination in these areas, including against women and children.

In the programs implemented in some Health Districts, the strategy is to transform the health centers into “youth friendly” centers with a trained youth educator ensuring the interface between the health center and the youths in the community³⁸. The strategy also aims at strengthening the capacities of youth educators to provide leadership in the “Youth for Youth” clubs set up in schools and in the Youth and Leisure Centers. Life skills in preventing HIV/AIDS is an integral part of the awareness raising strategies for youths in health centers and in the primary school curriculum, although its implementation is not as yet particularly perceptible.

While efforts are still under way to make free treatment available for all PLWHA, the provision of such care by health services rose from 3 to 48 sites in 2006, with free testing³⁹. It is also necessary to extend and strengthen PMTCT and the number of maternity centers which practice prevention, care and treatment of children and mothers⁴⁰, nutritional and feeding advice for nurslings and young children. The implementation of the strategic framework and the strengthening of the CNLS, as well as the popularisation of the new legislation is aimed at improving coordination between the actors and going to scale in order to achieve national coverage in the area of PMTCT, access to ARV (including paediatric treatment), protection of OVC and prevention, especially among youths. These steps also aim at establishing links between care for orphans and assistance to the national network of associations of PLWHA as well as technical and financial support to the network of youth’s associations in the country and in institutions.

7. Lessons learned

Many lessons have been learned over the past three years which are pertinent for acceleration of progress toward the achievement of the relevant MDGs and the priorities areas of a WFFC. These lessons will stimulate new initiatives and can be integrated into planning of future activities.

Some lessons are overall with a general application to the creation of a WFFC.

- Many of the major decisions made over the past three years, the reorientation of strategies and the implementation of many activities are integral elements of the process leading to a WFFC. However, the commitment made by the Government during the UN Assembly General in 2002 and the concept of a WFFC is not well known in Benin, even in the services of the main ministries involved. Consequently, there may be weaknesses in mobilising resources and in providing orientation as well as the loss of potential synergy between actors. It is necessary to inform all actors involved and to hold fora and common strategic planning sessions in order to target the MDGs and the specific objectives of a WFFC. The process of drafting the present report is a first, very positive step, in such a process.
- Although the average level of an indicators or the average level of access to social services have practically all increased, the poorer sections of the population are always disadvantaged. More direct targeting of poorer sections of communities should follow a

³⁸ Promoting discussion among youths on sexuality, access to low cost care for STI and free and voluntary HIV testing.

³⁹ 100 000 persons tested in 2006 as compared to 35 000 in 2003 ; 700 persons treated each quarter in 2005 as compared to 300 in previous years.

⁴⁰ Although PMTCT is being gradually integrated into regular mother and child services and is presently working in 185 maternal homes, 61% of maternity homes still have to be covered.

more detailed analysis of the causes of the problems identified. This point is also pertinent for the revision of the PRSP-II.

- Communication in general and in particular communication for behavioural change is recognized as being essential for sharing the aims and ideals of a WFFC with the population and authorities involved. The media can play an important role, in particular the local radios which could be mobilized by negotiating contracts to promote reporting on topics related to a WFFC. Properly designed and implemented, a communication component could also usefully mobilize youth educators and community relays.
- The drafting of a law, its approval and enacting are vital steps in improving children's situation and creating a WFFC. However, it is obvious that, on their own, these laws will not induce behavioural change. First of all, the new laws – but also many of the older laws – need to be better known by the public⁴¹ and to be effectively applied in a concerted way by actors at different levels while communities have to be mobilized to respect these laws. A positive step taken by the MFFE, for example, has been to make an overall plan to disseminate information on three laws instead of three different plans initially proposed on the suppression of FGM, sexual and reproductive health and the Persons and Family Code.

The same can be said for the numerous policy and strategy documents which are not always applied on a practical level. More thought is needed on processes which would provide wider access to information for development agents, civil society and the general public.

- The low level of spending of available financial resources (both from the national budget and externally funded projects), results in a low level of implementation of planned activities which means that objectives are not met. An improvement in the spending capacity of the financial resources available for projects, programs and services is essential by reducing administrative bottlenecks and creating partnerships with NGOs or other reliable institutions to manage programs.
- There is a need to strengthen in practical terms the coordination at national level of activities of donors and other actors to obtain more optimal use of available resources: developing partnerships, dialogue and better coordination of activities between State organizations, civil society and LAs produce better results.
- Developing partnerships and better coordination of activities, together with commitment from the Government and donors, is needed to implement progressively the principles of the Paris Declaration (support to priority Government programs, budgetary support), leading to better results and better monitoring of progress.
- Activities which had success in promoting behavioural change (parity in girls-boys schooling in LAs; extending PMTCT and its integration into regular health centre activities) were often carried forward by particularly motivated and dynamic persons, who were respected by the other persons involved and provided the leadership needed. In addition, real participation and involvement of communities in design, implementation, and monitoring of activities will lead to appropriation by them and is seen to be essential.

Other lessons are more specific to the different WFFC priority areas.

Lessons learned: Priority Area 1 – Promoting healthy lives

- Recent concentration on activities targeting survival on new-borns⁴² can have a rapid impact on the reduction of neonatal mortality and thus on infant mortality. They are

⁴¹ For example, the minimum age for work and apprenticeship at 14 years old

⁴² Materna I and neonatal care (better antenatal care and birth attendance, qualified assistance, emergency obstetrical care), EPI +, IMCI +

particularly important and must be carefully monitored and systematically supported while people must be informed of their logic and their effective impact.

- Other activities having had an important impact on the reduction of child mortality have been the wider use of treated bednets and the supplementation of children with vitamin A. These measures have to be pursued, strengthened and accompanied by the promotion of immediate and exclusive breastfeeding in order to be even more effective.
- Vaccination is still bringing positive results. However, cultural and religious resistance can sometimes be the cause of serious problems and must be prevented⁴³.
- The high level of chronic malnutrition, the absence of a large scale national program for weight monitoring and a national protocol which covers detection, reference and treatment, in particular in high risk areas, is a major handicap for preventive and curative health approaches to a reduction of children's morbidity and mortality.

Lessons learned: Priority Area 2 – Providing Quality Education

- The decision to support community initiatives for preschool education will certainly allow many interesting experiences in the field, which will be undertaken by Government structures and NGOs with support from different partners. It will be necessary to design and implement an appropriate strategy to provide support.
- The demand for education which is being encouraged by awareness raising on schooling shows that the educational offer (classrooms, teachers) is insufficient. Synergy is needed between different actors to solve this problem.
- Poverty of rural areas, especially in the north, handicaps children's access to school and their remaining in school for a full cycle, especially for girls. The abolition of school contributions decided by the Government and the payment of part of school running costs by some LAs and different partners is encouraging parents to send all their children to school. Through exchanges between the various organisations involved, the Ministry and civil society, other means can be put into effect to strengthen this movement, such as: reducing women's workload (a water point for every 250 inhabitants, a push cart for every women's group), the organisation – with support from MCI – of a credit system for productive and service activities, support for associations of pupils' mothers or covering part of the cost of keeping a child in school (free activity books and other supplies), the girl to girl system, etc.
- Keeping children in school, especially girls, has become a major problem which is closely linked to a child's capacity to follow (hence the need for school canteens) and parents willingness. However, keeping a child in school is linked above all to teaching quality and thus to teacher qualification. The principal lesson is that priority must be given to training the teachers already working, half of whom have been recruited by the local communities without any prior training, most often with a very low level of qualification. A second priority is to recruit new teachers with a higher level of initial training and give them an adequate initial training. Lastly gender equity among teachers must be improved.
- Recent low progress of education indicators and the low level of school productivity are linked to the high proportion of unqualified teachers, the weaknesses of pedagogical support to teachers and teacher strikes. All three factors have to be tackled at the same time in order to improve access to and staying in school so that the full cycle is completed by pupils. Synergy of interventions by different partners is essential, through joint implementation of the Ten Year Plan.

⁴³ Although refusal of vaccination by some religious groups has now been settled, there is still some reluctance to vaccinate ("vaccination causes fever..."). Nevertheless, refusal to vaccinate against polio in several Northern States of Nigeria by religious leaders has led to new infections by the wild virus in all the neighboring countries including Benin, interrupting a several year period without confirmed cases.

- The increase in schooling and the proportion of children who stay in school will be accelerated by the Government decision to make primary schooling free of charge, meaning that increasingly large numbers of children will finish primary school and create an increasingly strong demand for secondary school studies. But many children will not want to continue studies or will not have the means to do so. In anticipation, an important effort is needed to make secondary school more accessible and, at the same time, promote technical and professional training, including alternative methods (non formal education, dual apprenticeship, trade training centres...) and the means of integrating the labour market. Given that the minimum legal working age is 14 years and the improvements expected in school productivity, thought has to be given to the education of an increasing number of children aged 12-14 years who will finish primary school and will be too young to work.
- School statistics have been improved but they are still far from perfect and are not often used as a tool for planning and evaluating progress, an essential process to monitor progress towards reaching the objectives which have been fixed. This question must always be a priority for deciders and technical and financial partners.

Lessons learned: Priority Area 3 - Protection

- Protecting children is only touched on in the PRSP-I and the issue of children's vulnerability is not tackled. Efforts are under way to include these issues in the PRSP-II.
- Making additional judgements on undeclared births in regular court hearings will make them more difficult and more expensive, especially for poorer households and will thus make it impossible for their children in grade 6 to take the primary school leaving exam (CEP) as they will not have a birth certificate. Strong advocacy is therefore needed to organise external court hearings in order to reduce costs or to set up alternative methods such as training auxiliary village registry agents or the automatic civil registration of all children who start primary school, the pupils' files being prepared by the teacher and forwarded to the registry office.
- Advocacy is needed to set up an efficient birth registration program for children up to 15 years old and a system which will lead to systematic registration of births. Once the political will is declared, a detailed programme is needed together with adequate resources and an information program (see RAVEC), followed by effective implementation and a monitoring mechanism.
- Increased involvement of the civil society and the synergy between civil society, Government and international institutions, following the example of work done to combat child trafficking is extremely positive, improves children's rights and the process of attaining the WFFC objectives.
- Improved piloting of activities would be possible with an intersectorial approach. A joint committee could be set up in each LA which would promote education, health and protection as well as interaction between these three aspects. Mobilization of energy and initiatives at LA and community levels is needed and eventually the merging into a single community structures of the various committees dealing with these different areas.
- FGM are no longer practiced openly in order to avoid repression, but the practice has moved towards the borders with neighbouring countries, showing the need to adopt a sub-regional cooperation program.
- The Benin-Nigeria cooperation agreement to combat child trafficking across the border is a model for the rest of the region.
- In all protection activities, the need to protect vulnerable children against HIV/AIDS must be undertaken with increased youth involvement, as well as a program to access correct information and appropriate skills and services.

Lessons learned: Priority area 4 – Combating HIV/AIDS

- Local initiatives and youth groups are organised and many activities are undertaken without ideas being exchanged enough and without sufficient support, especially as concerns working methods for close-up communication and useful communication supports. An activity is needed which will provide support, facilitation and mediation services and lead an exchange forum between the different projects and youth groups, ensuring their training, furnishing communication supports and undertaking documentary work to build up on experience and disseminate information on best practices
- Planning and undertaking communication have obviously become important as they encourage community acceptance of PMTCT. The involvement of youth educators has been positive as it has led to more youths testing for HIV infection.

In conclusion, the report brings out the important efforts which have been made at different levels of responsibility over the past few years. Many activities have been realized in the field, working with the population and many initiatives have been taken, some of which have benefited from important support. All these efforts have been direct contributions to progress in achieving the MDGs and more precisely for a World Fit for Children. At the same time, important efforts have been made in designing and approving policies, strategies and major programs in order to undertake large scale operations, responding to real problems met in the field and analysed beforehand. These changes are now being implemented but have not yet had the expected impact on the population. Nevertheless, they provide the basis for faster improvements in the coming years, and thus a change in the corresponding indicators.

However, this hope of improvement cannot be met unless efforts are pursued and strengthened over a long period, if the aim is really to create a World Fit for Children.

ANNEXES

Annex 1: Statistical information on common WFFC/ MDGs indicators

Table I: Progress towards achievement of the MDGs in Benin 1990 – 2015

| | 1990 | 2000 | 2005 | 2015 (target) | |
|---|--------------|--------------|--------------|------------------|------------------------------|
| MDG 1: ERADICATE EXTREME POVERTY | | | | | |
| Target 2: Halve, between 1990 and 2015, the proportion of people who suffer from hunger | | | | | |
| Proportion of under 5s who are underweight | 28 (1996) | 23 (2001) | | 17 | (On track) |
| MDG 2: ACHIEVE UNIVERSAL PRIMARY EDUCATION | | | | | |
| Target 3: Ensure that children every where, boys and girls complete a full course | | | | | |
| Gross enrolment ratio in primary school | 59,9 (1992) | 79,99 | 94,84 (2005) | 100 | (On track) |
| Net enrolment ratio in primary school | 62,62 (1998) | 51,3 | 77,05 (2005) | 100 | (On track) |
| MDG 3: PROMOTE GENDER EQUALITY AND EMPOWER WOMEN | | | | | |
| Target 4: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015 | | | | | |
| Girls/boys ratio in primary schools | 0,50 (1993) | 0,67 | 0,80 (2005) | 1 | Ratio should be 1 since 2005 |
| Girls/boys ratio in public secondary schools | 0,38 (1993) | 0,40 (1998) | - | 1 | (Not on track) |
| MDG 4: REDUCE CHILD MORTALITY | | | | | |
| Target 5: Reduce by 2/3, between 1990 and 2015, the under 5 mortality rate | | | | | |
| Under 5 mortality rate per 1000 live births | 167 (1996) | 160 (2001) | | 56 | (Not on track) |
| MDG 5: IMPROVE MATERNAL HEALTH | | | | | |
| Target 6: Reduce by 3/4 between 1990 and 2015, the maternal mortality ratio | | | | | |
| Maternal mortality ratio | 498 (1996) | 474 (2002) | | 390 | (Not on track) |
| MDG 6: COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES | | | | | |
| Target 7: Halt and begin to reverse spread of HIV/AIDS | | | | | |
| HIV Prevalence | | Not reliable | 2% | < 2% | ??? |
| Target 8: Halt and begin to reverse incidence of malaria and other diseases | | | | | |
| Malaria prevalence | | 118‰ | 113‰ | | (On track ???) |
| MDG 7: ENSURE ENVIRONMENTAL SUSTAINABILITY | | | | | |
| Target 10: Halve by 2015 the proportion of people without sustainable access to safe drinking water and basic sanitation | | | | | |
| % Households with access to safe drinking water | 56 (1996) | 61 (2001) | | 75 | (On track) |
| % Households with access to basic sanitation | 20,4 (1996) | 32,1 (2001) | | 60 | (Not on track) |

Sources: DHS 1996, DHS 2001, current statistics

Table 2: Estimation by the World Bank (in 2003) of the possibility of achieving the MDGs

| | 1990 | Target 2015 | WB: Logarithmic projections | | |
|--------------------------------|-------|-------------|-----------------------------|-----------------|-------------|
| | | | Latest available figure | 2015 Projection | Evaluation |
| MD 1: Extreme poverty | 35,4% | 17,7% | 16,3 | 6,1 | Yes |
| MD 1: Underweight children | 34,1% | 17% | 22,7% | 13,5% | Yes |
| MD 1: Stunting | 21,4% | 10,7% | 26,0% | 33,4% | No |
| MD 2: Schooling | 31% | 100% | 54,5% | 74,4% | No |
| MD 4: U5MR | 195‰ | 90‰ | 160‰ | Not available | Probably no |
| MD 4: Anti measles vaccination | 60,0% | 100% | 72,3% ⁴⁴ | 85,4% | No |
| MD 5: Assisted delivery | 54,3% | 100% | 73,2% | 91,8% | No |
| MD 5: Contraceptive use | 0,8% | 100% | 11,8% | 17,8% | No |
| MD 6: Malaria prevalence | 64,2% | 0 | 46,4% | 30,7% | No |
| MD 7: Access to drinking water | 43,5% | 71,7% | 61,3% | 78,3% | Yes |

Source: WB (TOVO et al), 2003.

Table 3A: Potentiality of achieving the MDGs in 2015 by department according to OCS

| | MDG 1: Eradicate extreme poverty | MDG 2: Achieve universal primary education | MDG 3: Promote gender equality and empower women | MDG 4: Reduce child mortality | MDG 5: Improve maternal health | MDG 6: Combat HIV/AIDS, malaria and other diseases | MDG 7: Ensure environmental sustainability | MDG 8: Develop a global partnership for development |
|------------|----------------------------------|--|--|-------------------------------|--------------------------------|--|--|---|
| Alibori | NO | NO | NO | NO | NO | Average | NO | NO |
| Atacora | Average ⁴⁵ | NO | NO | Average | NO | NO | NO | NO |
| Atlantique | Average | YES | YES | YES | YES | NO | Average | Average |
| Borgou | Average | NO | NO | NO | Average | Average | NO | YES |
| Collines | Average | Average | Average | NO | Average | Average | NO | NO |
| Couffo | Average | YES | Average | YES | Average | NO | NO | NO |
| Donga | NO | NO | NO | Average | NO | Average | NO | NO |
| Littoral | Average | YES | YES | Average | YES | Average | Average | YES |
| Mono | Average | Average | Average | Average | NO | Average | NO | NO |
| Oueme | Average | Average | Average | Average | YES | Average | Average | Average |
| Plateau | Average | Average | Average | Average | NO | Average | Average | Average |
| Zou | Average | Average | Average | NO | Average | NO | NO | NO |

YES = Probably ; Average = Potentially ; NO = Unlikely

Source: OCS, 2005; 2006

⁴⁴ 85% in 2005⁴⁵ A nutritional survey in the Atacora department (northern Benin) shows that the target 2 (MDG 1) is not on track.

Table 3B: Appreciation of the possibility to reach the MDGs (Monitoring by department, according to OCS)

| MDG | TARGET | OCS SYNTHESIS OF PROGRESS | OBSERVATIONS ON THE BASIS OF THE RAPPORT |
|-------|---|---|--|
| MDG 1 | Target 1: Halve the proportion of people living under the poverty line, and reduce the poverty index to 15% by 2015. | <i>Overall, only one department (Littoral) out of 12 seems to be relatively less poor and benefiting from reasonably good nutrition; it is doubtful if Benin can achieve the goal on a national level and in the other departments</i> | <i>Overall level of poverty has hardly changed since 1999-2000. Even in Cotonou (Littoral) important pockets of poverty persist</i> |
| | Target 2: Halve, between 1990 and 2015, the number of persons suffering from malnutrition. | | <i>In 2001, chronic malnutrition was very high among children aged 12-36 months (and even up to 59 months) and was much higher than in 1996</i> |
| MDG 2 | Target 3: Ensure that by 2015, universal primary education for all children of school age | <i>Primary school indicators show an overall trend which, if maintained, could probably lead to achievement of the goal, especially if girls schooling is emphasised</i> | <i>Régional gaps and girl – boy gaps may make it very difficult to reach this goal</i> |
| MDG 3 | Target 4: Eliminate gender disparity in primary and secondary education by 2005 and in all levels of education no later than 2015 | <i>Benin is still a long way from achieving this goal. Trends in the girls-boys ratios mean that extra effort is needed for girls schooling. In the area of local councillors, and the indicator on women's participation in decision making, differences are obviously still too large.</i> | <i>Even though the girls –boys gap is gradually decreasing, overall and local equality is necessary if all children are to attend school</i> |
| MDG 4 | Target 5: Reduce the child mortality ratio from 166.5‰ in 1996 to à 90‰ in 2015 | <i>Benin is still a long way from achieving this goal. Trends shown by data on child mortality do not allow for optimism</i> | <i>Even using the figure from the 3rd Census in 2002 ((145‰) which is better than the DHS figure for 2001 (160‰), the U5MR has not changed enough since 1996. the obstacle is the stagnation of the neonatal mortality ratio (38‰) which requires specific targeting</i> |
| MDG 5 | Target 6: Réduire the maternal mortality ratio from 498 in 1996 to 390 for 100, 000 live births in 2015 | <i>The trend in antenatal care and maternal mortality are positive. However, the low level of attended births in the Atacora/Donga, Borgou/Alibor and Mono/Couffo departments give rise to doubts that the target can be reached</i> | <i>Figures used for maternal mortality are from the health centers which do not register all maternal deaths (they are only about ½ the figure from the 1996 DHS and about 1/3 of the UN estimate)</i> |
| MDG 6 | Target 7: Reduce HIV/SIDA/STI prevalence | <i>Overall, halting and then reversing the spread of the AIDS pandemic is a problem area, especially in the Mono and Plateau departments. The low level of health center attendance does not auger well for a reduction of malaria and other major diseases</i> | <i>The number of sentry sites having increased in 2004, earlier figures are not comparable</i> |
| | Target 8: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases by 2015 | | <i>Use of treated bed nets can make a rapid improvement; hand washing before meals and after defecating can reduce diarrhoea</i> |
| MDG 7 | Target 10: Halve by 2015 the proportion of people without sustainable access to safe drinking water and basic sanitation | <i>As for housing and environmental resources, further efforts are needed to bring about a significant drop in the proportion of houses which are built with temporary materials for the walls and the floors as well as to slow down atmospheric pollution. If strong steps are not taken, there is little hope of halving the percentage of population without sustainable access to safe drinking water.</i> | <i>Access to safe drinking water is rapidly increasing in rural areas and overall access is on track. On the contrary, only slow progress is noted in access to basic sanitation (toilets, latrines)</i> |
| | Target 11: By 2015, achieve a significant improvement in the lives of 2/3 of slum-dwellers in Benin | | <i>Land tenure issues and the absence of a strategy to support inhabitants home building efforts are major handicaps</i> |

Source : MDG Departmental Report (OCS, 2006)

Annex 2: Statistical informations on specific WFFC indicators

Table 4: Indicators related to the overall Plan of Action of a World Fit for Children⁴⁶

| Indicators | 2000 Level | Most recent level achieved | Level targeted in 2010 |
|---|---|---|---|
| 1. PROMOTING HEALTHY LIVES | | | |
| IMCI-MCC | | | |
| Maternal mortality ratio / 100 000 live births | 1996: 498/100 000 (UN Estimation: 850/ 100 000) | | -1/3 = 332 / 100 000 |
| Neonatal mortality ratio | 1996: 38,2‰ | 2001: 38,4‰ | A priority |
| Under 5 mortality ratio | 1996: 166,5‰ | 2001: 160‰ (RGPH3 : 149,5‰) | - 1/3 = 105,8‰ |
| Birth delivery | 2000: public 64,3% ; private: 10% | 2005: 76% | Especially for youth |
| Antenatal consultancy ratio | 2000 : 86,7% | 2005 : 91% | |
| Low birth weight | 2000 : 13% | 2005 : 12% | - 1/3 = 8,7% |
| Exclusive breastfeeding at 4-5 months | 1996 : 2,4% | 2001 : 13,7% | 100% |
| Complementary solid foods in 6-9 months | Dna | 2001 : 65% | 100% |
| VACCINATION | | | |
| Complete vaccination of children | 1996 : 55,6% | 2001 : 59% | ≥ 90% for < 1 year at national level and ≥ 80% for all children |
| TT 2+ (pregnant women) | 2000 : 73% | 2005 : 40% | Eliminate maternal and neonatal tetanus by 2005 |
| Poliomyelitis cases | 2000 ^o : 1 case | 2006 : 0 cases | Eradicate polio and guinea Worm before 2005 |
| Introduction of new vaccines | 2000 : 6 vaccines | 2005 : 9 vaccines with pentavalent | |
| Cases of Guinea Worm | 2000 : 186 cases | 2006 : 0 case | |
| COMBATING ILLNESSES: | | | |
| Proven, cost effective actions against diseases and malnutrition (ARI, diarrheas, tuberculosis intestinal parasites, STI, HIV/AIDS, hepatitis) that are affordable and accessible | Not well applied and 66,8% of the population does not consult | More generally applied but 63% of the population does not consult | Actions are generally applied |
| Prevalence of malaria among < 1 year / 1-4 years | 2000 : 459‰ / 218‰ | 2005 : 490‰ / 197‰ | - 1/2 = 229‰ / 109‰ |
| % children < 5 years old sleeping under treated mosquito net | 2000 : 5% | 2006 : 41% | 60% of children < 5 ans and women sleep under treated bednet |
| NUTRITION : | | | |
| Malnutrition prevalence < 2 years (Underweight) | 1996 : 26,9% | 2001 : 21,0% | - 1/3 = 17,1% |
| Malnutrition prevalence < 5 years (Underweight) | 2001 : 22,9% | | - 1/3 = ~15,3% |
| Malnutrition prevalence < 5 years (Height/age) | 2001 : 30,7% | | - 1/3 = 20,5% |
| % of households using iodized salt | 2001 : 71,7% | | Eliminate iodine deficiency in 2005 |

⁴⁶ A selection of indicators is presented based on the 16 objectives 99 actions presented in the Overall Plan of Action of a World Fit for Children. Qualitative activities have been largely omitted, as no simple, pertinent indicators exist.

| | | | |
|---|---|---|---|
| % children 6-59 months receiving vitamin A | 2001 : 18,3% | Dec. 2005 : 94% ; May 2006 : 76% | Eliminate vitamin A deficiency in 2010 |
| Anemia prevalence in < 5 years (moderate, severe) | 2001 : 60% | | - 1/3 = 40% par 2010 |
| Anemia prevalence in pregnant W (moderate, severe) | 2001 : 48% | | - 1/3 = 32% par 2010 |
| DRINKING WATER AND SANITATION : | | | |
| % households with access to safe drinking water | 2002 : 38,9% | 2004 : 33,7% | - 1/3 = 29,4% (prepare universal access) |
| % households with access to basic sanitation | 2001 : 68,8% | 2005 : 65,9% | - 1/3 = 45,4% (prepare universal access) |
| % households having all that is needed for hand washing | 2001 : 1,8% | | 100% |
| 2. PROVIDING QUALITY EDUCATION | | | |
| Preschool enrolment ratio | 1996-97 : 2,8% | 2005-2005 : 3,3% | Expand and improve comprehensive early childhood care and education |
| Gross primary school enrolment ratio (B / G) | 2000 : 94,43% / 65,10% | 2005 : 105,22% / 84,09% | Have access to free, compulsory and quality primary schooling and finish the full cycle of studies. Anticipate and limit drop outs Eliminate gender gaps in education. |
| Net primary school enrolment ratio (B / G) | 1998 : 74,88% / 49,10% | 2005 : 84,95% / 68,87% | |
| Primary school completion ratio (B / G) | 1999-2000 : 54% / 27% | 2004-2005 : 62% / 37% | |
| Drop out rate in primary school (B / G) | 2001-02 : 7,67% / 9,18% | 2004-05 : 13,28% / 14,80% | |
| Repeater rate in primary school (B / G) | 2001-02 : 20,43% / 21,75% | 2004-05 : 16,65% / 17,36% | |
| ACCESS : | | | Schooling accessible for all children and youths; basic education affordable by all households. Identify children excluded from schooling (especially girls, working children and handicapped children). Access to basic education for children with special needs. Respond to particular schooling needs of children in crisis situations |
| Number of working children 6-14 years | 2002 : 480 000 | | |
| Number of refugee children from Togo with access to education | 2006: 2200 Togolese pupils in school in 2 refugee camps in 2004-05 (of whom > 60% went into a higher class) and 1800 in 2005-06 | | |
| QUALITY : | | | Guarantee quality of educational services (qualified teachers, non-formal education and alternative approaches recognized). Improve educational quality |
| % of qualified teachers | 1995-1996 : 83,3% | 2004-2005 : 49,8% | |
| 3. PROTECTING AGAINST ABUSE, EXPLOITATION AND VIOLENCE | | | |
| GENERAL PROTECTION | | | |
| Birth registration ratio for under 5 children | 2001 : 69,7% (77,7% en milieu urban) | | Develop systems to register every child at or shortly after birth |
| Number of Juvenile Courts | 8 Lower Courts | 2006 : 8 Lower Courts with Juvenile Chamber | Set up juvenile justice systems based on restorative justice |
| Number of specialized juvenile judges | 2006 : 2 | | At least 8 |
| Prevalence of female genital mutilations | 2001 : 16,8% | 2001 : 12,1% of 15-19 years | End harmful or traditional customary practices such as early and forced marriage and female genital mutilations which violate the rights of children and women |
| Number of non-accompanied refugee children (NAC) from | 2006: 265 NAC identified: care provided for 100% and 96% reunited. | | Provide protection and assistance to |

| | | | |
|---|--|-------------------|---|
| Togo taken care of and having benefited from family reintegration | Local Personnel benefited from strengthening of skills in child care | | refugees and displaced persons in accordance with international law |
| COMBATING CHILD LABOUR | | | Protect children from all forms of economic exploitation and from performing hazardous work, eliminate rapidly the worst forms of child labour |
| % of children undertaking dangerous or harmful work | Cotonou, Parakou, Porto-Novo, 2000: Over ¼ of working children at risk from accidents on the street; 2/3 of working boys at risk from intoxication or accidents in building work, painting/welding/soldering/coachwork, metalwork, mechanics (cars and industry) from hairdressing for girls | | |
| % poor households | 1999-2000 : 29% | 2005 (est.) : 28% | Mainstream action combating child labour into national poverty eradication efforts |
| 4. COMBATING HIV/AIDS | | | |
| INITIAL PREVENTION | | | |
| % of cases of HIV/AIDS among youths of both sexes from 15 to 19 years | 1985-2000 : 15-19 year olds constitute 2% of all cases | | Reduce HIV prevalence among youths of both sexes aged 15 to 24 years |
| PMTCT-PEADIATRIC CARE | | | Ensure that 80% of pregnant women have HIV/AIDS information, advice and prevention services; ensure effective treatment to reduce transmission of HIV from mother to child (private counseling, voluntary testing, access to treatment including ARV) |
| Number of voluntary tests | 2002 : 20 071 | 2005 : 101 852 | |
| Overall prevalence of HIV/AIDS in population | 2004 : 2,0% | 2005 : 2,1% | |
| Number. / % of maternity homes practicing PMTCT | 2004 : 55 / ~ 12% | 2006 : 185 / 39% | |
| Number of women treated in PMTCT | 2002 : 100 | 2005 : 1 990 | |
| Number of children infected by HIV with access to treatment including ARV | Dna | 2006 : 150 | |
| Number of OVC in school or apprenticeship | Dna | 2005 : 5 390 | |
| Number of OVC under care | Dna | 1450 | Create a supportive environment for orphans and girls and boys affected by HIV/AIDS (counseling, psycho-social support; school enrolment, access to shelter, good nutrition, health and social services on an equal basis with other children). |

Sources: Current statistics (Health, Schooling); DHS 1996/2001; RGP3

Annexe 3: Bibliographical references

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