AWARENESS Project
Benin Country Report
2002–2007

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The *Institute for Reproductive Health*, affiliated with Georgetown University in Washington, D.C., is a leading technical resource and learning center committed to developing and increasing the availability of effective, easy-to-use, natural methods for family planning.

The purpose of the AWARENESS Project was to improve contraceptive choices by expanding natural family planning options and developing new strategies and approaches to increase the reproductive health awareness of individuals and communities in developing countries.

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Acronyms

ABMS	Association Béninoise pour le Marketing Social et la Communication pour la Santé
ABPF	Beninese Association for Family Promotion
DHS	Demographic and Health Survey
FRA	Fondation Regard d'Amour
HOMEL	Hôpital de la Mère et de l'Enfant – Lagune
IEC	Information, Education, and Communication
IRH	Institute for Reproductive Health
KIT	Knowledge Improvement Tool
MIS	Management Information System
MOH	Ministry of Health
NGO	Non-governmental Organization
OSV-Jordan	Organisation pour la Santé et la Vie
PRB	Population Reference Bureau
PSI	Population Services International
SDM	Standard Days Method®
URC	University Research Corporation
USAID	United States Agency for International Develo

Country Program Summary
Benin

Benin became the first African country to introduce the SDM when the Ministry of Health (MOH) and IRH agreed in December 2000 to conduct a pilot introduction study in two urban centers, Cotonou and Parakou. The study determined that strong demand for the method existed; that the SDM could be offered effectively through existing service delivery channels; that there was a high degree of acceptability and continuation of use; and that the SDM could be used correctly and consistently.

The government requested IRH's help to expand delivery of the method nationwide, an effort that began in December 2004. As service sites multiplied, Benin participated in other international, multisite studies, including a long-term (up to two-year) follow up of users and a study to determine the impact of social marketing campaigns on SDM use, particularly comparing pharmacy and clinic-based services. There was no significant difference in correct use between clients who obtained the SDM through clinics and those who obtained it in pharmacies.

The government has included the SDM in national reproductive health norms, policies, and training protocols and materials - including a peer educator training manual for adolescents - and as a distinct modern method in the 2005 DHS. CycleBeads® have been added to the MOH procurement list. The AWARENESS Project, in collaboration with local partners, trained more than 600 providers countrywide, recording more than 12,000 SDM acceptors between 2004 and 2007. The SDM is currently offered in more than 150 public, community, and commercial sites in all 12 departments of the country. An evaluation of the integration process after three years showed that the SDM is well-integrated into the health system, and was offered in all visited clinics, where 57% of providers had been trained on the SDM. The Benin program serves as a demonstration site for neighboring francophone countries.

Although IRH's office in Benin closed in March 2006, SDM implementation continues. An assessment is planned for 2008 to determine the status of SDM services and identify need for further input.

I. Introduction

Source: CIA World Factbook 2008

Benin has an estimated population of approximately 8.4 million with an annual growth of 2.9 percent.[1] Contraceptive prevalence is low, and the number of unsafe abortions remains high. Modern contraceptive prevalence is only 7%, and 12% of women of reproductive age using contraception are using natural or traditional methods.[2] The estimated unmet need for family planning is 27%, mostly related to birth spacing.[3] Half of the Beninese population is under 15 years of age. As this group enters their reproductive years, the need for family planning services will increase.

To respond to this need, the Benin Ministry of Health (MOH) invited the Georgetown University Institute for Reproductive Health (IRH) to introduce the Standard Days Method® (SDM) through a pilot study in December 2000. This study took place in two urban centers, Cotonou and Parakou, where the Beninese Association for Family Promotion (ABPF), the local affiliate of the International Planned Parenthood Federation (IPPF), and the nongovernmental organization (NGO) *Organisation pour la Santé et la Vie (OSV-Jordan)* were implementing reproductive health activities. The results from the introduction study determined that strong demand for the method existed in Benin, the SDM could be offered effectively to the community through existing service delivery channels, acceptability and continuation of use with the method were high, and the SDM could be used correctly and consistently by Beninese couples. In April 2002, IRH held a meeting at the MOH to disseminate study results.

Based on study findings, the MOH included the SDM in it reproductive health norms and requested technical assistance from IRH to expand the delivery of the method nationwide. IRH opened an office in Benin and, in June 2004, hired a country representative to oversee SDM expansion. The Beninese MOH launched activities to scale up the SDM in December 2004. To date, the SDM is offered in more than 150 sites and through numerous community-distribution channels and pharmacies in all 12 departments of Benin. IRH closed its country office in March 2007, and held a dissemination meeting to share project achievements and lessons learned and transfer the SDM implementation responsibilities fully to the MOH and partners.

II. Objectives and Strategy

The main objective of SDM introduction in Benin was to expand access to contraceptive methods and serve hard-to-reach populations that previously had not used family planning. Through consultation with the MOH and USAID, IRH agreed to assist local partners to integrate

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[1] 2005 World Population Data Sheet. Washington DC: Population Reference Bureau (PRB).
[2] Kodjogbé, Nicaise, Gora Mboup, Justin Tossou, et al. 1997. Enquête Démographique et de Santé, République du Bénin 1996. Calverton, MD USA: Institut National de la Statistique et de l'Analyse Economique and Macro International Inc.
[3] PRB, 2005.

the SDM in a limited number of clinics and community-based distribution sites, and then transfer capacity to offer SDM to local NGOs and to the government of Benin.

In scaling up the SDM, IRH experimented with a variety of approaches including regular health clinics, mobile clinics, social marketing, and volunteer and paid community-based distributors. The program started with the three pilot study sites and expanded according to the need expressed by local health authorities and the commitment of partner organizations in the area. Overall, IRH worked to strengthen provider training; improve quality of care; ensure availability of CycleBeads®; and provide information and education to women and their partners, community leaders, policymakers, and health workers.

III. Activities and Accomplishments

IRH carried out the SDM expansion project in Benin through a strategically chosen core of NGOs, faith-based organizations, and public clinics selected through consultations with the MOH and USAID-supported cooperating agencies (CAs). Two staff in an IRH/Benin country office coordinated all activities and partners and ensured timely communication and reporting. The MOH, as primary partner, made the SDM an essential part of its family planning services. Six other key partners for SDM expansion included:

- *The Hôpital de la Mère et de l'Enfant – Lagune* (HOMEL), the MOH national family planning reference hospital, also involved in the introduction study
- The *Association Béninoise pour le Marketing Social et la Communication pour la Santé* (ABMS), an affiliate of Population Services International (PSI)
- The *Organisation pour la Santé et la Vie* (OSV-Jordan)
- The Beninese Association for Family Promotion (ABPF), and
- The *Fondation Regard d'Amour* (FRA)

These groups included the SDM in over 130 clinics, pharmacies, and community-distribution channels.

IRH ensured successful SDM introduction and incorporation into the regular service delivery system by training trainers and providers how to screen and counsel clients, building SDM into the on-going supervision system, providing information about the SDM to both women and men in the community, ensuring CycleBeads' availability where SDM services are offered; collecting data on SDM clients and services for reporting and management purposes; creating a supportive environment to facilitate sustainability; and conducting evaluations to inform service quality. Table 1 below shows each partner's involvement and what the partnership accomplished.

Table 1: Partnerships and Accomplishments

Collaborating organizations	Activities undertaken	Partner's Role	IRH's role	Accomplishments
Ministry of Health (MOH)	• Training of trainers • Training of providers • Method integration into national norms	• Trained trainers • Disseminated SDM messages to regional health departments and other NGOs	• Financed all activities • Worked with the MOH to coordinate trainings	• SDM integrated into the national reproductive health norm • SDM integrated into the peer educator training

Collaborating organizations	Activities undertaken	Partner's Role	IRH's role	Accomplishments
	and training manuals • SDM integration into the management information system (MIS) • SDM research activities • SDM inclusion in the Demographic and Health Survey (DHS) • SDM inclusion in supervision visits	• Coordinated provider trainings and supervision visits • Disseminated research results • Organized dissemination meetings • Participated in all SDM activities	• Supplied and coordinated distribution of CycleBeads • Provided technical support on SDM implementation • Helped coordinate supervision visits and data collection	manual • CycleBeads integrated into the reproductive health procurement document (*les produits sécurisés en santé réproductive*) • SDM integrated into the 2006 DHS • Cadre of SDM trainers available throughout the country • Number of SDM users increasing • Method fully integrated into method mix and considered essential part of national program • SDM integrated into pre-service curriculum
Beninese Association for Family Promotion (ABPF)	• Training of providers • Advocacy activities with religious and opinion leaders • Supervision visits • Youth reproductive health education program	• Planned and co-financed all SDM activities • Adapted IEC materials • Organized advocacy meetings • Provided SDM through clinics and community distribution channels	• Provided funding for SDM activities through a subagreement • Provided technical assistance for all SDM activities • Co-trained providers	• Reached more than 500 religious and opinion leaders with family planning messages in general and SDM in particular • Recruited more than 1000 SDM users • Initiated a youth sexuality education program
Association Béninoise pour le Marketing Social et la Communication pour la Santé (ABMS)	• IEC activities at the national level • CycleBeads distribution through private sector	• Developed, tested, and produced IEC materials including TV and radio spots, posters, brochures, etc. • Introduced the SDM into private clinics and pharmacies through social marketing • Adapted CycleBeads insert to the local context • Participated in SDM research	• Funded all SDM activities through a subagreement • Co-trained trainers • Co-trained providers from a network of franchised private clinics (ProFam) • Provided technical assistance on all IEC, training, and advocacy activities • Conducted research	• SDM integrated into social franchising project including 21 private clinics in and around Cotonou • Significant contributor to the promotion of modern family planning use in Benin (increase in male involvement, increase in the use of other methods, buy-in from religious and opinion leaders) • CycleBeads integrated into family planning commodity distribution channel, the central warehouse • SDM available in pharmacies in major cities

Collaborating organizations	Activities undertaken	Partner's Role	IRH's role	Accomplishments
Fondation Regard d'Amour (FRA)	Integration of the SDM in two clinics and through community distribution in the districts of Abomey-Calavi, Allada, Sô-Ava, Savalou, Bantè, Aplahoué, Sakété, and Pobè	• Led all SDM implementation activities in Abomey-Calavi, Allada, Sô-Ava, Savalou, Bantè, Aplahoué, Sakété, and Pobè. • Adapted IEC materials • Conducted advocacy activities with religious and community leaders • Organized reflection days for youth on family planning	• Co-funded all SDM activities through a subagreement • Provided technical assistance on implementation • Followed and supervised activities to ensure quality services	• SDM introduced into two clinics and numerous community-distribution channel serving the Tofinu people, a hard-to-reach population in a village on Ganvi Lake with very low contraceptive prevalence • SDM integrated into the weekly health discussion on Catholic radio
OSV-Jordan	• Dissemination of the SDM in Cotonou, Mananville, and Parakou • Integration of the SDM into two clinics and door-to-door distribution • Involvement in SDM studies	• Implemented SDM services in areas of coverage • Participated in the pilot study • Participated in other SDM studies, including the long-term follow-up, and the social marketing study • Co-trained trainers and providers • Participated in supervision activities	• Funded all SDM activities through a subagreement • Trained trainers • Provided technical assistance on all SDM implementation aspects	• Increased number of family planning users in general and SDM users in particular in OSV project areas • Disseminated study results • OSV-Jordan became the SDM point organization providing technical assistance to other organizations • Successfully dispelled myths and rumors about family planning among rural women by using CycleBeads

A. Research

As the first African country to introduce the SDM, Benin benefited from participation in numerous studies and conferences and became the SDM regional demonstration site where neighboring francophone countries including Burkina Faso, Cameroon, and Mali could learn from its experience. The program in Benin carried out the following research activities:

i. SDM introduction study

The major objectives of the study were to test and document incorporation of the SDM into health programs in Benin, measure correct use and continuation of the SDM, assess how women/couples use the SDM, and estimate user acceptance and satisfaction. Researchers implemented the study over a 23-month period in selected sites in Benin: *Maternité Lagune* and OSV-Jordan in Cotonou, and ABPF in Parakou. The number of women who expressed a desire

to use the method was high during the study (1,179). However, only 338 were deemed eligible[4] and received the method. Of those, 219 agreed to participate in the study. Study results showed that the SDM is culturally appealing to couples in Benin, primarily due to its scientific basis and ease of use. Nearly half (45%) of women who adopted the SDM during the study had never used any contraceptive method. Most couples who used the SDM stated that they were very satisfied with the method. About 25% of users consistently declared that the adoption of the SDM had improved their couple relationship, 90% would recommend it to others, and most said they would continue to use the method. The most cited reasons for adopting the SDM were the fact that the SDM has no effect on the woman's health (26%) and has no side effects (14%). The positive results of this study motivated the MOH to scale up the program countrywide.

ii. Long-term follow-up study

To assess continuation and correct use over time, OSV-Jordan and IRH collaborated on a long-term follow-up study with users from the SDM pilot study. Among the 219 clients registered in the pilot study, 154 accepted to participate in the follow-up study. Women were interviewed at three, six, twelve, eighteen, and twenty-four month of SDM use. Results showed that clients can use the SDM correctly over time. At the end of the study, most clients continued to use the SDM for about two years, and efficacy of the method remained high. Abstinence was the most cited mode of managing fertile days (52%), while 22% used condoms and the remainder used both.

iii. Social marketing study

Benin was part of a multi-country (Democratic Republic of Congo, Bolivia, and Benin) social marketing study conducted in collaboration with *OSV-Jordan* and the *Centre de Recherche en Reproduction Humaine et en Démographie* and *Populations Services International (PSI)*. The objectives were to: 1) evaluate the impact of a social marketing campaign on awareness of and demand for the SDM; 2) follow clients and compare correct use among those who obtained the method in clinics and in pharmacies; and 3) compare the quality of information and services provided in clinics and pharmacies.

Researchers interviewed some 800 women and 400 men as part of the community survey both pre- and post-intervention. In the baseline, only 25% of men knew about the SDM, but this increased to 72.5% at the end line. A similar increase was observed among women. People heard about the SDM through television (47%), health center personnel (47%), friends and family (12%), radio (11%), and posters or brochures (10%). Almost all respondents, both men and women, agreed that the price of CycleBeads should stay at the government-designated 500 FCFA. Clients who obtained the SDM through clinics used the method more correctly than those who received it in pharmacies. Quality of care followed the same pattern. The results of the social marketing study suggest that, while training pharmacists is an important step to support correct SDM use, additional efforts are necessary to ensure that information about correct use is available at the community level and that point-of-sale materials are both available and understood by clients who purchase CycleBeads at these venues.

[4] At the time this study took place, tools to facilitate screening for method eligibility had not been developed, resulting in a large percent of women who actually were eligible to use the SDM being identified as ineligible.

iv. Evaluation

Three years after the launch of the SDM, IRH assessed the status of the method in Benin. The objective of this evaluation was to assess the integration process and to measure SDM user satisfaction. The study also examined the degree to which providers accepted the SDM, including their knowledge and skills in counseling clients about correct use. Finally, the study explored client and partner perceptions regarding the quality of SDM counseling they received and obtained their suggestions for service delivery improvement. Information was collected through semi-structured interviews, in-depth interviews, and focus group discussion. During the study, 85 SDM users were interviewed, including female and male users, trainers and supervisors, health service providers, and community health animators. The assessment showed that the SDM is well integrated into the health system. Most providers (57%) had been trained on the SDM. Among the trained providers, 46% were midwives. Almost all clinics had some documentation on the SDM, and most (80%) conducted some kind of family planning awareness-raising activities that included the SDM. Providers rated the initial SDM training they received "very good" (70%) or "good" (for the rest). All providers knew they could offer the SDM to women with menstrual cycles between 26 and 32 days long or those who report that they have their periods about once each month.

B. Building awareness and support for the SDM

Because the SDM was a new family planning method, it was important to provide key stakeholders with information about method efficacy and how it could contribute to their programs. In Benin, IRH identified key stakeholders in different sectors to obtain support for SDM introduction and then held presentations and workshops to present research findings with important service delivery implications. Conferences were also good venues to present information on the SDM. For example, the SDM was featured in a technical presentation at the 8th Congress of the African Society of Obstetrics and Gynecology held in Benin in December 2004. More than 1,500 health professionals from 15 countries attended this meeting. A direct result of IRH's participation was the inclusion of the SDM in the reproductive health norms in Mali and in requests for information and training from several other countries.

IRH collaborated with the MOH to include the SDM in national reproductive health norms, policies, and training protocols. CycleBeads are now included in the MOH procurement list. The MOH included the SDM in its peer educator training manual (*Module de formation pour pairs éducateurs/Jeunes Ado*) to enhance fertility awareness among adolescents. It also included the SDM as a distinct modern method in the 2005 DHS instruments. This indicates recognition of the SDM as a mainstream choice, and enabled IRH to assess SDM use from survey results.

As a result, many organizations that were skeptical about the SDM, including pre-service schools and religious organizations, began integrating the SDM into their reproductive health programs. More providers were convinced about the effectiveness of the method and started offering it as a choice.

IRH, in collaboration with PSI/Benin, worked to create awareness of the SDM at the national level through posters, TV and radio spots, and the inclusion of SDM information in public-

A community provider wearing a promotional SDM shirt catches the attention of a couple on the street.

service advertisements. SDM advocates promoted the method in health fairs and community events and informed policymakers through workshops and special briefing meetings. PSI/ABMS participated in IRH's social marketing study examining the feasibility of adding the SDM to services provided by selected health facilities and pharmacies in Benin. In collaboration with PSI, IRH trained more than 100 providers who offer the SDM in the twenty-three ProFam franchised reproductive health clinics serving low-income people in urban areas of Cotonou. The ProFam network includes trained doctors, nurses, midwives, and pharmacists united under a common logo signifying quality services.

IRH worked with ABPF to involve religious leaders in support of family planning. ABPF organized workshops with Muslim leaders, voodoo priests, and community leaders in various villages to talk about the importance of family planning, in general, and the SDM, in particular.

C. Developing the capacity of local organizations

IRH trained a cadre of eight master trainers from the MOH, PSI, OSV-Jordan, and ABPF who then trained providers and served as supervisors throughout the implementation process. Training followed a cascade model with the Institute training national trainers who work with IRH local staff and master trainers or supervisors to train providers in a one-day or two-day training, depending on the trainer's skill level. The training covered information about the method and practice in SDM counseling for providers with some family planning counseling skills or experience. IRH also trained a "lower level" cadre of providers on the SDM, which has had an important effect on expending access to the method. The team used several universal principles to enhance quality. For example, the program worked to ensure that the SDM is offered as part of a range of methods and services. SDM counseling stressed the importance of treating clients with respect and tailoring counseling, services, and methods to individual preferences, knowledge, beliefs, skills, needs, and concerns about contraception. Supervisors incorporated provider skill assessment into regular supervision visits through the use of IRH's Knowledge Improvement Tool (KIT), which enables them to assess provider skills essential to quality SDM services and to implement or propose remedial solutions as part of the supervision process.

Capacity development efforts included the following:

- IRH provided the MOH with extensive technical assistance in training and supervision and involved it in the support of other NGOs. The MOH included the SDM in 21 government clinics throughout the country and made it an essential part of its family planning services because it meets the needs of large, traditional subgroups that prefer natural methods.
- OSV-Jordan is a local NGO offering both clinic and community-based reproductive health

services to underserved populations in Parakou, Mananville, and Cotonou. OSV-Jordan participated in the introduction study and in several SDM studies. As such, OSV became an important technical resource for SDM. IRH trained three OSV-Jordan trainers who trained more than 100 community distributors and providers, both from their three family planning clinics in Cotonou, Parakou, and Mananville, and from other partner organizations. OSV-Jordan also conducted door-to-door distribution of the SDM in the Zou Colline region as part of the SDM expansion activities called "Promo Collier" ("CycleBeads promo").

- ABPF, an NGO whose mission is to promote reproductive health while emphasizing family planning, introduced the SDM into five urban clinics. IRH provided technical assistance and materials to help educate religious and community leaders about the importance of family planning, including the SDM.
- FRA is an NGO that works in Abomey-Calavi, Allada, Sô-Ava, Savalou, Bantè, Aplahoué, Sakété, and Pobè. FRA has one clinic and a network of community-distribution channels that serve the Tofinu people—a hard-to-reach population that lives in a village on Ganvi Lake and that has very low contraceptive prevalence. FRA workers, who understand the community dynamics of this unique fishing village, move by canoe to educate women and men about family planning. They provide the SDM to eligible couples and refer others to nearby clinics.
- ProFam, PSI's franchise of private clinics serving low-income urban groups in parts of Cotonou, introduced the SDM into 22 of its clinics. PSI developed a low-literacy and culturally appropriate insert and a calendar specific to Benin. PSI managed the distribution of CycleBeads in the early stages of the project. Since September 2005, the MOH decided that CycleBeads, like all other contraceptive commodities, should be placed at the central distribution warehouse.

Table 2: SDM Service Statistics

Name of organization	Number of Providers Trained		Number of Sites with Trained Providers	Number of Trainers Trained	Number of SDM acceptors April 2002 –Dec 2007
	Clinical	Community based & Pharmacies			
MOH	221	0	0	21	4,500
ABPF	16	40	23	6	1,124
PSI/ABMS	60	71	14	4	1,600
Fondation Regard d'Amour (FRA)	4	30	2	3	429
OSV-Jordan	16	85	57	8	2,894
Institut Pontifical Catholique	2	8	2	2	Data not available
Peace Corps	2	22	Data not available	2	Data not available
Total	**321**	**246**	**98**	**46**	**10,547**

To ensure the sustainability of SDM training capacity, the project introduced core faculty members from various medical and paramedical institutions to the SDM. This training resulted in the integration of SDM into the curriculum of several pre and in-service programs.

In developing the SDM prototype curricula, IRH collaborated with the *Réseau Population et Santé de la Reproduction en Afrique Francophone*, a West African regional institution headquartered in Togo. Prototype SDM curricula were pre-tested at the *Institut National Médico-Social*, a national nurse-midwifery school, and the *Faculté des Sciences de Santé*, the national medical school. Since then, other schools have integrated parts of the SDM curricula into their respective teaching and training programs. For example, the *Institut Régional Pontifical Catholique Jean Paul*—a regional faith-based training institution in Benin—has integrated the SDM into its ongoing pre-marriage education.

D. Incorporating the SDM into reporting and logistic systems

In Benin, the poorly functioning family planning commodity distribution system has led to very low morale in government warehouse staff. Late reporting by family planning storehouses and stockouts at lower levels are chronic. The MOH decided to use the SDM introduction experience to resolve some of its warehousing difficulties. In order to integrate the SDM into the national data collection system, IRH worked with the MOH to add the SDM to clinic records and service statistic forms and in the regional and national reporting systems. IRH also worked with PSI/Benin to procure and supply CycleBeads to all partners. Family planning data collection generally improved in the sites where SDM was introduced, according to the Director of Family Health at the MOH, likely due to the regular supervision visits IRH organized with the MOH. The MOH used these visits to remind providers about the importance of timely submission of data to the central level.

Procurement of CycleBeads remains a problem. UNFPA and USAID are the major commodity procurers for the Benin MOH. At the time of this report, CycleBeads had not been included in the UNFPA procurement list USAID had combined all its health activities into two bilaterals: the Integrated Family Health Project, led by the University Research Corporation (URC), and the Integrated Social Marketing and HIV/AIDS Prevention Project, led by PSI. Although USAID agreed to purchase CycleBeads for URC and PSI for two years, continued procurement beyond that date is not clear. Through PSI, USAID procured 10,000 sets of CycleBeads for distribution in MOH clinics. With intensified community distribution activities started by IRH and the rapidly increasing demand for the method, this number will not meet even current need. PSI will continue to work with the central distribution warehouse to ensure that CycleBeads are well integrated into regular national distribution channels.

E. Summary of experience of SDM introduction and expansion

Through the AWARENESS Project, IRH and its partners provided couples in Benin with an additional family planning choice contributing to the reduction of unmet need. The program started in three centers and the SDM is now available in more than 150 clinics countrywide. Benin has more than 50 SDM master trainers, over 300 trained providers, and more than 65 community distributors. There are over 10,000 SDM users in Benin. According to family

planning service data provided by the MOH (April 2002–December 2007), SDM users represent 14% of new family planning acceptors.

Non-health programs, including micro-credit and youth programs, have also integrated SDM services. More than 90% of women choosing the SDM had not used a modern family planning method before; others have been dissatisfied with other methods. Almost all women who choose the method do so because it is "natural" and has no side effects. Programs are very satisfied with offering the SDM, and most report that SDM counseling presents an opportunity—and a comfortable context—to encourage and discuss condom use.

The MOH has included the SDM in its national reproductive health norms (*Protocoles des services de santé familiale),* the peer educator training manual (*Module de formation pour pairs educateurs/Jeunes Ado*), the peer educator reference manual (*Manuel pour pairs educateurs/Jeunes Ado*), the reproductive health procurement document (*les produits sécurisés en santé réproductive*), and in the 2006 DHS study instruments.

IV. Challenges

The Beninese government historically has not considered family planning a priority. As a result, programs in Benin have suffered from weak central organization and coordination. Since the start of the SDM expansion program in Benin, the Director of Reproductive Health has changed at least three times. The pilot introduction followed a strict study protocol. For example, women who did not know the dates of their period were not admitted into the pilot introduction. After scale up started, some providers did not understand that it was not important for the woman to remember the exact day of her period as long as she had her periods about a month apart.

Constant personnel changes in the MOH, coupled with following strict SDM eligibility criteria rules used during the pilot study, have hindered progress. For example, IRH tried to work through the MOH to schedule and coordinate all supervision visits, but often there was no one in charge of this activity. Some clinics denied men SDM services if their wives did not accompany them. Lack of field support funds to engage in more robust community distribution and IEC materials' development has also been a barrier. Although the mission originally requested IRH's assistance, future support did not materialize. Instead, the mission asked its two cooperating agencies, PSI and URC, to include SDM in their work. Given their broad scope of work, it was difficult for these agencies to develop technical expertise and maintain focus on the SDM. Additionally, the weak central MIS and commodity procurement mechanisms made data collection very difficult and procurement of CycleBeads challenging.

By working with partners, IRH addressed most of these issues. IRH identified "champions" or committed individuals in the MOH and worked with them on different reproductive health issues. For example, IRH, in collaboration with the World Health Organization/USAID Implementing Best Practices program, initiated a national family planning best practice committee. IRH helped the MOH draft a supervision schedule that was mostly driven by SDM supervision. Nonetheless, challenges remain. Given that IRH closed its Benin office (due to lack of field support), these challenges will need to be addressed through long-distance assistance and the ongoing efforts of partners in Benin.

V. Lessons Learned

- Frequent changes in leadership created a challenge for achieving sustainable SDM services.
- The SDM contributed to efforts to increase contraceptive prevalence in Benin, as it was well accepted by the community. IRH partners developed culturally sensitive IEC materials and offered the SDM in an informed choice context.
- Programs involved in the early stages of SDM introduction needed special help to implement new screening guidelines and reduce medical barriers to the SDM.
- Community-based SDM services have proven successful in reaching rural Benin and the Muslim community; more community outreach to fully inform these populations and provide needed services is recommended.
- Programmatic research is needed, particularly in the areas of adolescents and youth, transition from the SDM to other methods and vice versa, and provider bias.
- Well-trained providers are better equipped to meet their clients' needs. Benin has enjoyed the presence of an IRH staff member and multiple local supervisors who frequently refreshed the technical and communication skills of providers.

VI. Future Plans

The Benin office closed in March 2007 and the responsibility for SDM implementation transferred to partner organizations. The project disseminated results of the SDM integration; donated office materials to the MOH and OSV-Jordan; and discussed SDM service continuation with the MOH, USAID, and local partners. PSI will continue to promote the SDM as part of the IMPACT project and supply the MOH with CycleBeads. ABPF will fund its SDM activities through cost recovery from CycleBeads sales. IRH will continue to provide long-distance technical assistance to all partners and explore opportunities for funding. It is important to expand SDM coverage through local partners working in the new USAID geographic coverage areas (Northern Benin) where the Integrated Family Health Project is the primary cooperating agency.

Priority activities include:

- Strengthen supervision in MOH clinics.
- Conduct periodic field monitoring and supervision of active sites, using the KIT as a job aid.
- Intensify IEC activities undertaken by partners, including PSI.
- Work with educational institutions including nursing schools, medical schools, and schools of midwifery to complete the integration of the SDM into their curricula.
- Train additional SDM providers, thus expanding services within existing government sites.
- Continue behavior change communication activities, including reproduction of materials and organization of community-based social mobilization activities.