

BASICS II Country Report

BENIN

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 **BASICS II**

BASICS II

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BASICS II COUNTRY REPORT: BENIN

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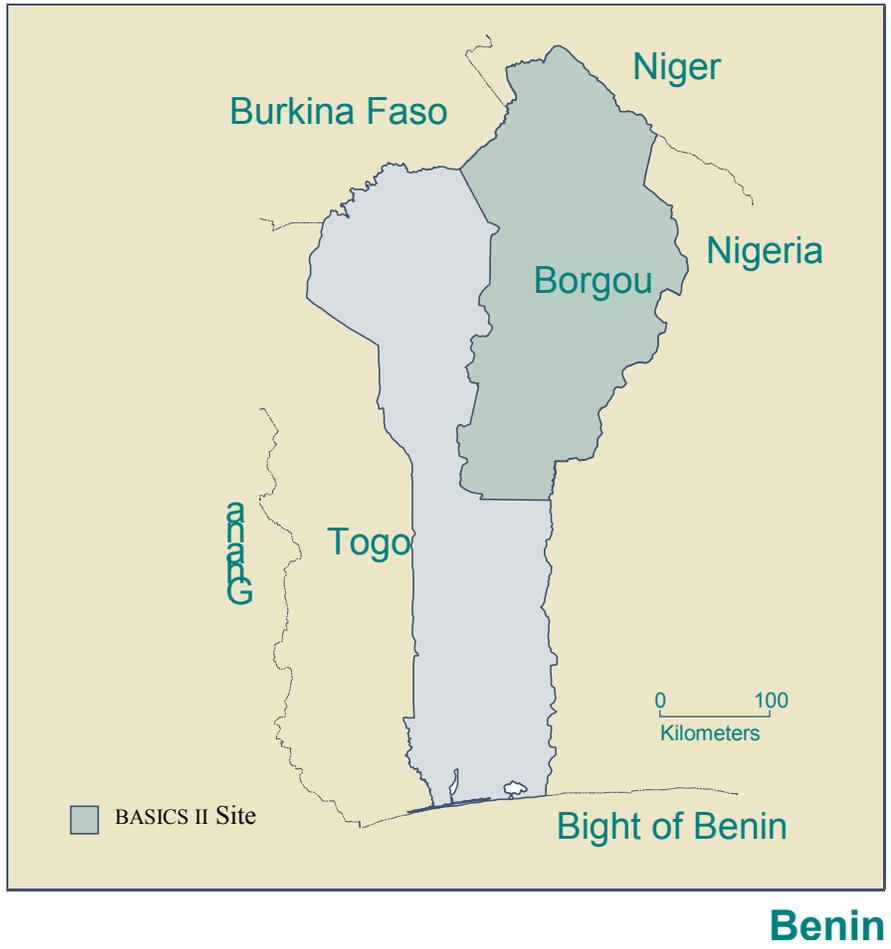
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COUNTRY MAP WITH BASICS AREAS OF IMPLEMENTATION



ACRONYMS

BASICS II	Basic Support for Institutionalizing Child Survival
BFHI	Baby Friendly Hospital Initiative
CBC	Communication and Behavior Change
CF	Complementary Feeding
CPS	<i>Centre de Protection Social</i>
CRS	Catholic Relief Services
DDS	<i>Direction Departmental de la Santé</i>
DHS	Demographic and Health Survey
EBF	Exclusive Breastfeeding
ENA	Essential Nutrition Actions
EPI	Expanded Program on Immunization
GTZ	<i>Gesellschaft für Technische Zusammenarbeit</i> (German development aid agency)
IEC	Information-Education-Communication
IFA	Iron and Folic Acid
IRSP	Regional Institute of Public Health
LAM	Lactational Amenorrhea Method
MADLAC	<i>Monitoreo del Apopo Directo en Lactancia Materna</i> (breastfeeding monitoring)
MCH	Maternal and Child Health
MOH	Ministry of Health
MOU	Memorandum of Understanding
NGO	Non-governmental Organization
NID	National Immunization Day
OPD	Outpatient Department
PMA/Nut	<i>Paquet Minimum d'Activités de Nutrition</i>
PPS	Population Proportionate to Size
PROFILES	Nutrition advocacy tool
PROSAF	<i>Promotion Intégrée de Santé Familiale</i>
PSP	<i>Projet Santé Population</i>
PVO	Private Voluntary Organization
SANA	<i>Service Alimentation et Nutrition Appliqué</i>
SNIG	Routine Health Management Information System
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

This report describes the implementation of the Essential Nutrition Actions (ENA) approach in the Borgou department of Benin and the process of scaling up nationally. The period covered is from 1997 to 2003. This document identifies key factors of success. Its intent is to share lessons learned from departmental and national experience in Benin with other public health programs in Africa and elsewhere. The program has been introduced to other countries through regional networks.¹

In 1998, based on an overall assessment of the health and nutrition situation of the country, an evidence-based, results-oriented approach to accelerating nutrition was advocated using the ENA, known as the *Paquet Minimum d'Activités de Nutrition* (PMA/Nut) in Benin. The PMA/Nut package contained six key actions:

- (1) exclusive breastfeeding (EBF) for infants up to about six months of age;
- (2) complementary feeding (CF), with continued breastfeeding from six to 24 months;
- (3) vitamin A supplementation;
- (4) iron and folic acid (IFA) supplementation for pregnant women;
- (5) iodized salt promotion for the general population; and
- (6) nutritional assessment and counseling of the sick child.

The PMA/Nut program in Benin got off to a quick start in 1997–1998 due to early involvement and ownership by the *Direction Départementale de la Santé* (DDS) and other stakeholders possessing the capacity to implement the communication component, train, and link health facilities with communities. Some results were rapidly visible. A Catholic Relief Services (CRS) survey carried out in August 1999 in the CRS impact area (encompassing selected communities in the Borgou department) showed a clear improvement in EBF rates in infants under four months of age (40%) from about 14% in the 1998 Demographic and Health Survey (DHS).² Two other surveys in selected areas in the Borgou department, carried out by the U.S. Agency for International Development (USAID) bilateral, *Promotion Intégrée de Santé Familiale* (PROSAF), in January 2000 and September/October 2002, confirmed this EBF trend (53% and 61%, respectively). In addition, the DHS II survey, which was conducted in 2001, showed a clear upward trend in the entire Borgou Alibori department of about 47%.

The PMA/Nut program built capacity within the health sector to carry out the six key components of PMA/Nut. A cascade-training model was used, starting in the initial four *sous-prefectures*. This was later expanded to include the other *sous-prefectures* of the Borgou department.

Knowledge and awareness of the importance of iodized salt was another important action within PMA/Nut. Selected communities were involved in testing the level of iodine in the salt, and there

¹ For example, an agreement was signed with the Regional Institute for Public Health (IRSP in French) for ENA to be a part of IRSP's teaching activities in nutrition and behavior change and communication. IRSP is a World Health Organization (WHO)-funded regional training institution that offers a Master of Public Health and a Master of Epidemiology to medical doctors from all African countries. One of the main reasons for this collaboration in nutrition was to take advantage of the fact that Benin was implementing the ENA package and that IRSP was interested in strengthening its nutrition curriculum.

² In Benin, the Ministry of Health (MOH) policy for exclusive breastfeeding (EBF) was targeting children up to four months of age.

was some coordination with *Service Alimentation et Nutrition Appliqué* (SANA), the governmental unit responsible for this program.

Vitamin A supplementation conducted at first with the National Immunization Days (NIDs) strategy and then outside the NIDs strategy is another example of PMA/Nut success. Attempts were also made to strengthen the inclusion of vitamin A supplementation into routine activities; however, coverage was still quite low. When NIDs began implementation in Benin, the United Nations Children's Fund (UNICEF) was approached for adding vitamin A to one of the NIDs rounds, which started in 1997 in the Borgou and Atacora departments. As the need for assuring a second dose was recognized, non-NIDs national distribution was initiated in 2001. As part of PMA/Nut, Borgou spearheaded the first non-NIDs vitamin A supplementation in Benin in a pulse fashion, with an innovative three-pronged strategy through:

- (1) health facilities;
- (2) outreach; and
- (3) special outreach throughout the Borgou and Alibori departments.³

This strategy resulted in coverage of about 60% of children 6–59 months of age. The Borgou experience paved the way for the first national non-NIDs vitamin A supplementation in 2002. The first nationwide experience yielded impressive coverage of about 83%.

There are a number of lessons that have been learned through implementation of the program:

- Participatory situational analysis, operations research, and baseline surveys carried a very important weight in the design of the intervention. This is due to two main factors: the involvement of local people from the start and the quick turnaround of the results into action;
- Political desire to support the program was key to the success of the program within and beyond the department;
- Capacity-building was a very important building block in the program; for the first time, health workers had a holistic view of nutrition and a focus on defining specific actions (e.g., counseling for caretakers);
- The DDS was able to leverage several donors in support of PMA/Nut. The *Projet Santé Population* (PSP), funded by the World Bank, supported several PMA/Nut training sessions and the development of similar tools in other departments. Support also came from the Swiss, the *Gesellschaft für Technische Zusammenarbeit* (GTZ), non-governmental organizations (NGOs) (e.g., CRS). UNICEF also funded PMA/Nut training in other parts of Benin; and
- The link between the health system and the community through influential personalities in the community was essential for the penetration of messages into different communities.

The next phase for PMA/Nut is the implementation of the PMA/Nut platform throughout the entire country. This scale-up involves several challenges for the central MOH. The country is undergoing administrative decentralization in addition to decentralization within the public health sector. This means that departments and health zones will need to plan for PMA/Nut implementation, including the budgeting of resources. With the newly elected local government, there will be opportunities for advocacy and involvement in behavior change activities. The

³ The Borgou department was split into two departments: Borgou and Alibori. In 2003, the health activities in the Alibori department are still supervised by the Borgou DDS.

consensus workshop held in Parakou in early 2002 was a very important step, but now it is of paramount importance to follow up on the conclusions of the workshop and also to look critically at the next steps. Certainly, the implementation of PMA/Nut should have an impact on other divisions of the MOH, such as central medical stores. Various logistics assessments undertaken by PROSAF for Borgou-Alibori department clearly show that the stock-outs within the supply system have impacted on the quality of care. This could have an effect on anemia prophylaxis for pregnant women and children and the new vitamin A intervention.

1. BACKGROUND AND CONTEXT

Public Health Situation and Key Issues

The 1996 DHS highlighted that Benin had serious nutritional problems. With an under- five mortality rate of 166 per 1,000 and a malnutrition rate of 29% low weight for age and 25% low height for age in children below three years of age, a programmatic intervention on nutrition to accelerate coverage was both important and urgent.⁴

Malnutrition rates were highest in the Borgou department in 1996 (35% underweight), and several partners, including the United States Agency for International Development (USAID), elected to concentrate their support. Ongoing nutrition interventions were mostly focused on food availability and nutrition rehabilitation, nutrition education, and increased use of local foods and food supplementation programs. With the introduction of the Essential Nutrition Actions (ENA) package (locally known as the *Paquet Minimum d'Activités de Nutrition* or PMA/Nut), health services—previously not major players in battling malnutrition in Benin—now had a programmatic response to the malnutrition problem.

USAID Child Survival Program

Summary Overview of Timeline for BASICS and Geographic Scope

The objective of the program was to deliver a set of proven actions at the health facility as well as at the community level and to reinforce key nutrition behaviors through a communications program to improve the nutritional status of mothers and children. Beginning in one region, the program was designed to work at national scale with a five-pronged approach:

- The PMA/Nut design/start-up phase in one region;
- A health system strengthening component;
- A community development component;
- A large multimedia component; and
- Scale-up to the national level.

The PMA/Nut start-up included operations research, tool design and testing, and collaborative work planning to build ownership within the units of the *Direction Départementale de la Santé* (DDS). The mass media component included developing Information-Education-Communication (IEC) material for radio spots and newspapers, etc. The health system strengthening included training (PMA/Nut approach, technical issues, and tools used to pass messages along to mothers and/or caretakers about nutritional facts) for health workers, adaptation of the health information system, and technical assistance with supervision. The community level encompassed training for community volunteers on key simple and do-able messages with the intention of linking the health system to the communities. Representatives from the community were brought into the process of message and IEC support development. Community theatre groups (youth group and

⁴ As in most of Sub-Saharan African countries, Benin continues to have high infant and child mortality, with the DHS II 2001 indicating 89 deaths per 1,000 live births for the former (far from the 2000 goal of 69 per 1,000) and 160 per 1,000 for the latter.

women) as well as traditional singers were involved in the design and dissemination of messages for communities. A monitoring and evaluation element was included in each component of PMA/Nut.

Expansion of the PMA/Nut approach followed two different paths. Informally, the PMA/Nut approach was introduced in other departments as personnel who had worked in the Borgou department were transferred to other departments during routine turnover within the Ministry of Health (MOH). These health workers were especially interested in continuing to use IEC materials (such as the counseling cards), and several were planning to conduct PMA/Nut training for their new colleagues. Formally, after the successful experience in the Borgou, the MOH decided to expand the PMA/Nut approach to other departments. MOH interest and commitment to expand PMA/Nut was facilitated by the MOH central staff involvement in various stages of development of the PMA/Nut approach, including operations research, training, and implementation.

2. TECHNICAL APPROACH

After the development of a ‘nutrition minimum package’ for maternal and child health programs in 1997⁵, USAID supported its introduction in three preliminary African countries as part of comprehensive child survival programs. Benin was one of the three countries where this approach was first introduced (Senegal and Madagascar were the other two). The ‘minimum package’ is now called Essential Nutrition Actions or ENA.

The ENA package contains six interventions and aims to reach 80% coverage with each:

- (1) exclusive breast feeding (EBF) through 6 months of age,
- (2) appropriate complementary feeding from 6 to 24 months,
- (3) Vitamin A supplementation,
- (4) iron and folic acid (IFA) supplementation,
- (5) iodized salt promotion for the general population, and
- (6) nutritional care and counseling for the malnourished and sick child.

The problem of malnutrition was well recognized before the program started. In 1996, DHS results highlighted that Benin had widespread and severe nutritional problems. With an Under Five Mortality Rate of 166 per 1,000 and malnutrition rates of 29% low weight for age and of 25% low height for age in children under three, a programmatic strategy for nutrition was urgent. Malnutrition was estimated to be associated with 46% of all deaths among children under five in Benin (DHS, 1996). Three-fourths of these deaths were associated with mild and moderate forms of malnutrition (rather than severe malnutrition). The DHS analysis showed that nutrition interventions focused on prevention could make a large contribution to reducing child mortality.

At the start of the program, malnutrition rates were highest in the Borgou Region at 35% low weight for age (DHS 1996). WHO classified Benin as having a clinical vitamin A deficiency problem of public health significance (WHO, MDIS Working Paper #2). The Borgou region is similar in ecology to northern Ghana where a 20% reduction in mortality was found to result from vitamin A supplementation. Exclusive breastfeeding (EBF) levels were very low. Half of all infants in Borgou terminated EBF at about 15 days (DHS 1996). Only about 16% of newborns were breastfed in the first hour. Diarrhea rates were high and closely related with deterioration in nutrition status.

In the mid-1990s, the country was rapidly decentralizing, and the department of health in Bogou emerged with the progressive commitment to innovation in health planning. This is where several partners, including USAID, elected to concentrate their support. However, the national policy context was not particularly conducive to accelerating nutrition coverage. Policy statements in Benin in 1996-1997 did not clearly articulate what the priority nutrition interventions were or what targets and approaches were to be used. General activities such as IEC, measuring

⁵ BASICS/USAID, 1997. *Improving Child Health Through Nutrition*. Pamphlet; WHO/UNICEF/BASICS Nutrition Essentials, 1999.

children's heights and weights, and improved feeding are mentioned in the National Health Policies and Strategies of 1997-2001. In the field, nutrition activities were mostly focused on food security and nutrition rehabilitation, nutrition education, and the increased use of local foods, including food supplementation programs.

With the 1997 introduction of the Essential Nutrition Actions package (locally known as PMA/Nut), health services—which until then did not play major roles in battling malnutrition—now had a programmatic response to the malnutrition problem.

Before this approach was adopted, nutrition activities had been scattered across various ministries and few were well implemented. The Ministry of Agriculture and the Ministry of Social Affairs were responsible for most nutrition promotion activities, while the Ministry of Health dealt with treating clinical malnutrition. In addition, there was little integration of nutrition activities with routine health services. The six interventions of the ENA approach were already mentioned in the MOH policy. Apart from the duration of exclusive breastfeeding (which in Benin in 1997 was promoted only up to four months of age), the stated national standards were consistent with international standards. The implementation of activities to achieve these standards was limited. Delivery strategies in operation were non-existent or not successful in achieving high coverage. For example, EBF, already part of the MOH policy, focused on the Baby Friendly Hospital Initiative (BFHI). However, there are relatively few births in hospitals and the EBF rates were still low. Vitamin A was poorly distributed in the country through the normal routine service with a low coverage rate. The distribution of Iron Folic Acid (IFA) tablets to pregnant women was part of the prenatal package but the quality of counseling and compliance was poor.

The new ENA approach addressed several operational issues:

- (1) defined a target of 80% coverage for each of six interventions and identified delivery strategies to reach this target,
- (2) gave priority to age groups most at risk (pregnancy through 2 years) and preventive rather than curative elements in the program,
- (3) specified simple and practical actions that could be implemented by health workers and community members to raise coverage,
- (4) linked the interventions with ongoing systems in health and other sectors and community networks, to assure quality and sustainability, and
- (5) convinced health managers to launch multiple interventions as a package since nutrition problems frequently occur in a cluster simultaneously and some share delivery strategies. Furthermore, this implementation of the package of interventions helped to promote some of the lesser known or recognized interventions in the package and balanced the program.

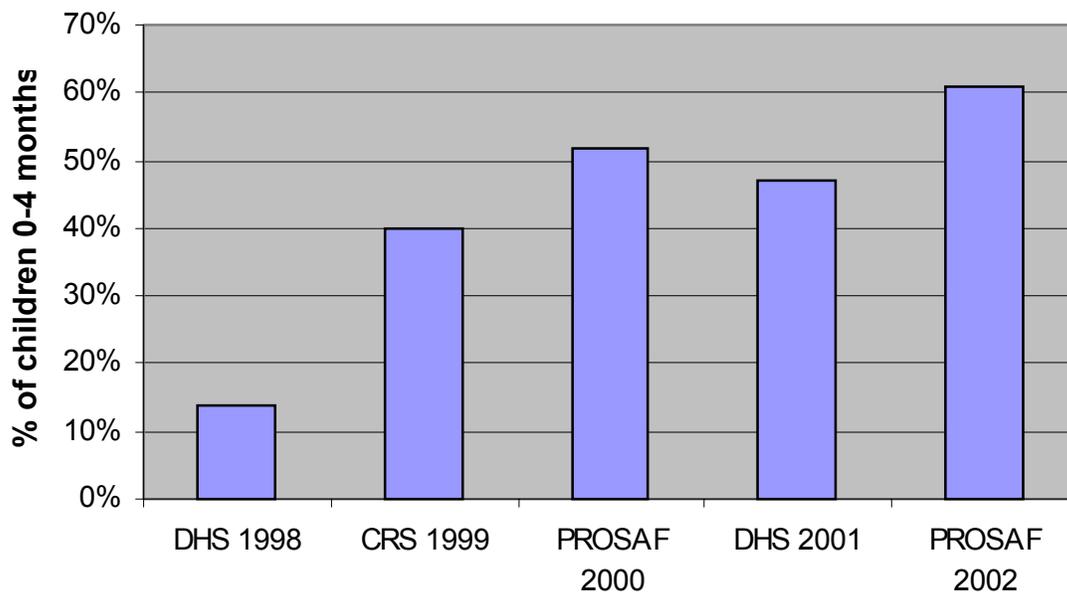
The PMA/Nut program built capacity within the health sector to carry out the six key components of PMA/Nut. A cascade-training model was used, starting in the initial four *sous-préfectures*. After two to three months of implementation, expansion to the other 10 *sous-préfectures* started with constant consolidation through supervision. While this was taking place, a spill-over effect was noticed as other regions also adopted some of the tools. The national level was both informed and involved through formal and informal mechanisms. In addition, the assessments carried out in the beginning had the full involvement of the national MOH.

3. RESULTS

Breastfeeding Practices

The PMA/Nut program in Benin began rapidly in 1997–1998 due to early involvement and ownership by the DDS and other stakeholders possessing the capacity to implement the communication component, train, and link health facilities with communities. Some results were quickly visible. A Catholic Relief Services (CRS) survey carried out in August 1999 in the CRS impact area (encompassing selected communities in the Borgou department) showed a clear improvement in EBF rates in infants under 4 months of age (40%) from about 14% in the 1998 DHS.⁶ Two other surveys in selected areas in the Borgou department, carried out by the USAID bilateral *Promotion Intégrée de Santé Familiale* (PROSAF) in January 2000 and September/October 2002, confirmed this EBF trend (53% and 61%, respectively). In addition, the DHS II survey conducted in 2001 showed a clear upward trend in the entire Borgou-Alibori department⁷ of about 47% (Figure 1).

Figure 1. Exclusive Breastfeeding Trends



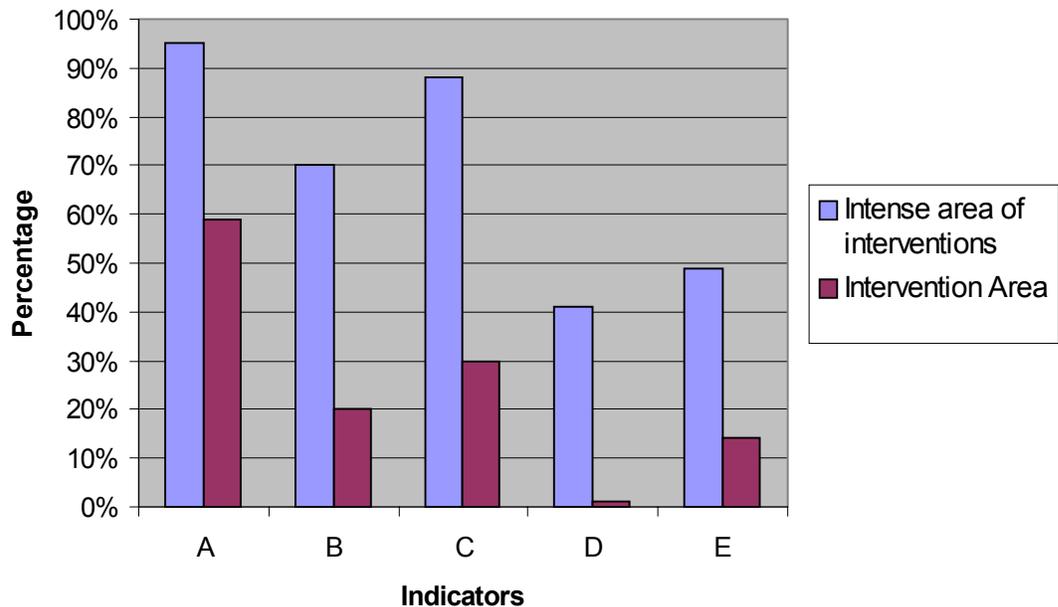
The plausibility of behavior changes being related to the program was confirmed by a household survey that BASICS II carried out to assess the impact of the communication strategy and to evaluate whether the messages had reached the targeted audience. The survey was stratified by

⁶ In Benin, the MOH policy for EBF was targeting children up to 4 months of age.

⁷ The Borgou department was split into two departments: Borgou and Alibori. In 2003, the health activities in the Alibori department are still supervised by the Borgou DDS.

pilot and non-pilot areas. The results found an increase in caretaker knowledge on all of the health messages aired through the different channels (radio, theater, and volunteers). In the pilot *sous-préfectures*, breastmilk was the first “food” mentioned by 95% of caretakers, while in the non-pilot area the figure was 60%. Seventy percent (70%) of the caretakers in the pilot area declared that they should put the baby to the breast immediately after birth, compared with a rate of 20% in the non-pilot area. In the pilot area, 88% said they should exclusively breastfeed their children for four to six months, while in the non-pilot area only 30% of the caretakers mentioned EBF between four and six months. Additionally, 46% declared that if their child is sick, they should breastfeed him/her more often, in contrast with 1% in the non-pilot area. Lastly, 49% of women in the pilot area declared that while a woman is pregnant, she should take an Iron and Folic Acid (IFA) tablet every day until delivery, compared with 12% in the non-pilot area (Figure 2).

Figure 2. Improved Household Knowledge of Key Practices



Indicators in Figure 2: (A) Breastmilk as first food (B) Put baby to the breast immediately after birth. (C) EBF for four to six months (D) Breastfeed when child is sick. (E) Take IFA tablet daily until delivery.

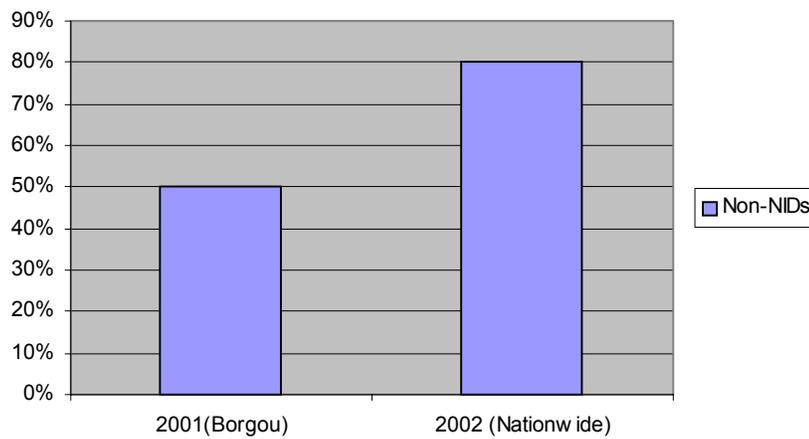
Knowledge and awareness of the importance of iodized salt was another important action within PMA/Nut. Selected communities were involved in testing the level of iodine in the salt and there was some coordination with *Service Alimentation et Nutrition Appliqué* (SANA), the governmental unit responsible for this program.

Vitamin A Supplementation

In keeping with the PMA/Nut principle of accelerating nutrition coverage through linking with existing activities, vitamin A supplementation was first conducted nationwide with polio National

Immunization Days (NIDs), and later conducted outside the NIDs strategy. This is an example of a health systems-driven component that was critical for the success of PMA/Nut in reaching 80% coverage. At first, there was an attempt to strengthen adequate integration of vitamin A into routine activities; however, coverage was still low. Therefore, BASICS spearheaded the first non-NIDs vitamin A supplementation in a pulse fashion, with an innovative three-pronged strategy through (a) health facilities, (b) outreach, and (c) special outreach throughout the Borgou and Alibori departments, resulting in a coverage of about 60% of children 6–59 months of age. The Borgou experience paved the way for the first national non-NIDs vitamin A supplementation in 2002. The nationwide experience yielded about 50% coverage in its first round.

Figure 3. Vitamin A Coverage



4. PROGRAM CONTENT AND MILESTONES

Evolution of the Program

In 1998, based on an overall assessment of the health and nutrition situation of the country, an evidence-based, results-oriented approach to accelerating nutrition was advocated using ENA (PMA/Nut), called PMA/Nut package, as previously noted.

Before this approach was adopted, nutrition activities had been scattered across various ministries, and few were implemented with clear targets and strategies for achieving high coverage. Ministries such as the Ministry of Agriculture and the Ministry of Social Affairs were responsible for most nutrition promotion activities, while the MOH dealt with treatment of clinical malnutrition. In addition, there was little integration of nutrition activities within the health system itself.

The six actions of the PMA/Nut approach were already part of MOH policy and were consistent with national standards, but the strategies in operation were not successful in achieving the desired level of coverage. For example, EBF was already part of MOH policy and the Baby Friendly Hospital Initiative (BFHI) helped to spread the message. However, EBF rates were still low. Vitamin A was poorly distributed in the country through the normal routine service and had a low coverage rate. Distribution of IFA tablets to pregnant women was part of the prenatal package, but the quality of counseling was poor.

What set the PMA/Nut approach apart from previous nutrition efforts was that it sought to strengthen capacity in the MOH to achieve high coverage more rapidly for a selected group of six interventions. Implementation of this package of interventions helped to promote some of the lesser known or recognized interventions in the package, defined specific actions for health workers, and placed emphasis on increasing coverage.

USAID was concentrating its efforts in health on the department of Borgou, and therefore implementation of PMA/Nut was to be initiated there. The program started in four *sous-prefectures*, or sub-regions, and subsequently expanded to encompass all 14 *sous-prefectures* in the Borgou department, in collaboration with other non-governmental organizations (NGOs) and with the USAID bilateral, PROSAF.

In the four *sous-prefectures*, tools were tested to ensure that their content provided suitable behaviors for vitamin A supplementation and breastfeeding practices, the latter based upon the *Monitoreo del Apoyo Directo en Lactancia Materna* (MADLAC) model. Health workers in the four *sous-prefectures* were trained in the whole PMA/Nut approach and the IEC tools. This was followed by a similar training for health workers in the remaining 10 *sous-prefectures*. A communication plan was put in place, focusing on three of the six actions (EBF, IFA tablets, nutrition management of the sick child) throughout the entire department. The three additional PMA/Nut interventions (vitamin A, complementary feeding, and iodized salt) were added in 2001. Feedback from health managers, health providers, and NGOs, in addition to results of NGO and PROSAF surveys and the vitamin A coverage data, reinforced the DDS view that the PMA/Nut approach was an effective and plausible program framework. After the initial success

of the PMA/Nut approach in the Borgou and Alibori departments, a national workshop was held in Parakou and resulted in the decision at the central level to adopt PMA/Nut and to include childhood anemia in the package. The IEC materials were adapted to reflect various cultural practices in different parts of the country, and other departments started training health workers on PMA/Nut.

Table 1. Milestones

Month/Year	Activity
1997 March	Putting Nutrition into “Health” with visits by consultants
1997 September	Designing PMA/N Borgou
1997 Nov/Dec	Vitamin A with NIDs in Borgou and Atacora
1998 Jan	<ul style="list-style-type: none"> • Hiring of country advisor • Planning for IEC workshop • Mini-evaluation = Vitamin A/ distribution into NIDs • Introduction training module for Vitamin A/NIDS - BASICS/ WHO/UNICEF
1998 April	<ul style="list-style-type: none"> • Module testing • decision to generalize the approach • testing community approach • MOU between MOH and BASICS signed
1998 May	<ul style="list-style-type: none"> • TIPs on Iron and Feeding practices • Health Facility Assessment
1998 July/Aug	Multimedia workshop
1998 Nov	Orientation for all 14 prefectures in PMA/Nut
1998 Dec/ 1999 Feb	Training on PMA/Nut
1999 March	Training for health workers on IEC material
1999 Feb–April	Radio spots and community speaker
1999–2000	Full intervention with IEC activities (Radio, printed material and theater groups) in all the 14 <i>sous-prefectures</i>
2001	Collaboration with PROSAF
2002	Scaling up to national level. Consensus workshop (funded by the World Bank)

Details of Implementation

An action-oriented assessment of nutrition activities in Borgou, carried out by the DDS in collaboration with external consultants at the beginning of the program, produced a very sound workplan. It was the first time the health team of the region reviewed what nutrition actions were actually being implemented in peripheral facilities and surrounding communities. At first, a series of quick formative research studies were carried out to help tailor the approach. These studies examined infant feeding practices, compliance with prenatal IFA tablets, the use of traditional media, and the design and testing of information systems. Vitamin A-specific IEC materials and exit interview tools designed to monitor appropriate breastfeeding practices were developed. These were based upon the MADLAC model.

From the very start, the DDS had a strong sense of ownership of PMA/Nut. In all subsequent activities, DDS staff took the lead in training material adaptation and design, implementation of surveys and studies, and organization of small workshops for the training of DDS and health zone staff.

Program Start-up

Start-up activities included a participatory situational analysis, the development of operations research, baseline studies, and testing and development of key tools. A number of gaps were identified by the situation analysis. Chief among them was the lack of a national nutrition strategy for the MOH, lack of a clearly articulated strategy for vitamin A, and the non-inclusion of the lactational ammenorrhea method (LAM) as part of breastfeeding promotion activities. The PMA/Nut approach helped narrow the focus to six proven interventions and helped prioritize what could be feasibly accelerated.

A series of studies were undertaken for the IEC components. Surveys were used to elicit community participation throughout the development of CBC activities. Two consultative research activities using trial of improved practices techniques were conducted: one on child feeding practices and the other on iron supplementation for pregnant women. The results provided a wealth of information that was used to tailor messages to the specific conditions of the targeted populations, to identify traditional media existing in the area, and to research coverage of the two main local radio stations (Parakou and Banikora). Results also provided other population information sources to ensure complete and consistent coverage of the target population. These rapid qualitative studies were conducted to better reflect the sociocultural context and population needs. An assessment of the IEC material showed that there was an insufficiency (qualitative and quantitative) of the nutrition-related materials. The result of the traditional media survey identified specific factors to be considered in the materials and messages design: the popular nature of the media, the value of entertainment, and the ability of dealing with social problems. It is important to note that these surveys were conducted using mainly local expertise.

A health facility assessment (HFA) was undertaken to better understand the health workers' skills and daily work environment. An important strategy for accelerating nutrition coverage was to link key interventions with ongoing health services. The HFA used various tools to achieve this: observation of the encounter between caretaker and health worker, exit interviews of caretakers, and health worker interviews for outpatient departments (OPDs) and maternal and child health (MCH) clinics. Additional tools were developed to monitor EBF and vitamin A.

Communication Strategy

A new model for accelerating the development of IEC messages and materials was designed and implemented. An innovative multipurpose workshop that included three sub-workshops developed the same content for different communication channels: (a) traditional media, (b) print material, and (c) radio. Community representatives—such as traditional communicators, youth groups, women's groups, health workers, university professors and graduate students, journalists, and artists—fully participated in the workshop. Such a rich and diverse array of participants was conducive to on-the-spot production of a range of well-adapted IEC products.

Furthermore, the pre-testing of the material was done through an iterative process during and after the workshop, and, for the first time, health workers were trained in how to use these educational materials.

Critical elements of this workshop (which resulted in a strong communications strategy) included: the acceleration of materials production; the engagement of local decision-makers by setting up a departmental follow-up committee; and an emphasis on pre- and post-testing of the materials developed. The resulting IEC materials, later mass-produced, included:

- About 900 flip books for health workers;
- 20 radio spots (aired during four intensive months of broadcasts from March to June 1999);
- 500 audio cassettes (for health facilities, media, rural organizations, taxi and truck drivers, and royal courts);
- 20,000 counseling booklets (for health facilities, schools, NGOs, community development organizations, taxi drivers, military camps, libraries, political leaders, and members of royal courts); and
- Four dramas for theater groups.

Extensive training on and supervision of the use of IEC materials by health agents was conducted. The dissemination of messages was synchronized and used a variety of channels. Health facilities used the flip books and the audio cassettes that played messages from the theater groups. Community theater performed the dramas (84 sessions about 42 villages and neighborhoods). Community radio stations aired a number of products from the workshops such as spots, games, and theater dramas.

The development of tools, such as the flip book, was a response to an urgent demand expressed by health workers. After the dissemination of these tools, health workers mentioned often and with pride the tools they use at every IEC session, during prenatal services, at well-baby clinics, and at Expanded Program on Immunization (EPI) sessions. The health workers were very engaged in the tool development process, and a departmental follow-up committee has been set up to address issues that arose during the IEC development process.

Written agreements were established with radio stations and the Borgou DDS for the full implementation of the IEC programs at no cost to the project. (Similar agreements were also developed with theater groups that were involved in the dissemination of IEC messages.) Local and national radio stations aired the spots over a period of four months, with at least two spots per day. In addition, there was a very popular weekly radio game entitled “Superlatif.” This was an interactive “quiz show” that invited listeners to call in and respond to questions and several sessions on topics related to PMA/Nut were broadcast. In addition, several local newspapers ran articles on nutrition topics.

Health Systems Strengthening

As a result of the HFA, capacity building was a high priority of the program. The following are several activities of the program that addressed capacity building.

Health Worker Training

A set of training modules for health workers was developed in-country with DDS involvement. The training of health workers on the PMA/Nut approach began in the initial four *sous-prefectures*, following the cascade model. The training of trainers involved 16 health workers, who, in turn, trained 567 health workers. Immediately afterwards, the training was extended into the other 10 *sous-prefectures*. In addition, health workers were trained on the use of the flip book. In order to sensitize other partners to the IEC tools, a one-day workshop, during which regional partners were exposed to the PMA/Nut approach, was organized.

In order to assess the impact on health workers' performance, directly after the training on the IEC tools, a DDS team undertook a series of supervisory visits in the four *sous-prefectures*. Health workers were observed during their IEC sessions. Although there are no hard data on the impact of the training on health worker performance and knowledge, it was clear from interviews in the health centers and health posts that this training influenced the way they viewed nutrition. Nutrition was perceived as a key component of their duties, and they reported spending more time on nutritional actions than before the training. Furthermore, because nutrition had been the purview of other ministries (Agriculture and Social Affairs), the training involved workers from these sectors as well. Their activities became better linked to health facilities. As the Head of a *Centre de Protection Social* (CPS) of the Ministry of Social Affairs in Parakou said:

“Before the training we did not pay attention if the child needed vitamin A or the mother was pregnant. Since the training on PMA/Nut, these issues are part of our concerns: if the child needs vitamin A we give it to him and if the mother is pregnant we send her to the nearest health center.”

Leadership

At the outset, a cadre of national experts from West Africa (including Benin) was involved in regional initiatives to not only train workers, but also to build national capacity for a number of new and innovative approaches and tools, including consultative research methods for the adaptation of infant feeding recommendations and a World Health Organization (WHO) guide for developing radio spots. The trained national experts were asked to lead the process of in-country capacity building with technical oversight and support from BASICS. This process yielded significant benefits in cost reduction. For example, because journalists were trained on new methods of making radio spots, their companies agreed to air the PMA/Nut messages free-of-charge.

IEC Materials Development

Another key factor in the implementation of PMA/Nut was the revision of the Child Health Card and the Maternal Card to accommodate new nutrition actions, such as vitamin A for children 6–59 months and vitamin A for postpartum women (within eight weeks from delivery). These changes were also carried into the Routine Health/Management Information System (SNIG) in the Borgou and Alibori departments, ensuring data availability for management purposes.

Community-level Activities

At the community level, the *relais communautaires*, the link between communities and health facilities, were involved in the nutrition activities. The project conducted a workshop with community leaders to help identify *relais communautaires* to be trained on PMA/Nut. In addition, theater groups were strengthened and trained in adopting topics related to nutrition. These theater groups held several performances in the department with very large audiences.

The MOH coordinated community-level activities across donors. The USAID bilateral project (PROSAF) and other NGOs operating in Borgou, as well as CRS, the Swiss Cooperation, *Gesellschaft für Technische Zusammenarbeit* (GTZ), and others, worked together. PROSAF, for example, developed and applied a PMA/Nut module to train community volunteers. In fact, in the three *sous-prefectures* where PROSAF focused its community-level interventions, data show that volunteers do conduct home visits, and one of the topics on which they usually choose to focus is nutrition.

Expansion Phase

A consensus workshop was held in Parakou in early 2002 to pave the way for the adoption of the PMA/Nut approach throughout Benin. Senior health officials representing all regions of Benin were invited to the workshop, where the PMA/Nut platform was presented and discussed, and it was decided to extend PMA/Nut to the entire country. A subsequent workshop was held in Abomey, where adaptation of IEC materials to the different cultures of the country took place. It is noteworthy that childhood anemia was added to the PMA/Nut platform; previously, interventions combating anemia had been limited to pregnant women.

5. HIGHLIGHTS OF LESSONS LEARNED

Lessons Learned on How to Operationalize PMA/Nut

Several lessons have been learned through implementation of the PMA/Nut program:

- Operations research and baseline surveys were an important factor in the acceleration of nutrition programming in Benin. This is due to two main factors: the involvement of local people from the start and the quick turnaround of the results into action;
- Political desire to support the program was key to the success of the program within and beyond the department;
- Capacity-building was an important building block in the program; for the first time, health workers had a holistic view of nutrition and a focus on defining specific actions (e.g., counseling for caretakers);
- The DDS was able to leverage several donors in support of PMA/Nut. The *Projet Santé Population* (PSP), funded by the World Bank, supported several PMA/Nut training sessions and the development of similar tools in other departments. UNICEF also funded PMA/Nut training in other parts of Benin; and
- Effective communications strategies, and the link between the health system and communities through influential personalities in those communities, were essential to ensure penetration of messages into communities.

Key Elements to the Expansion of PMA/Nut

- Demonstrated technical leadership across various units of the DDS and at the highest levels;
- Immediate results showing progress;
- Attractiveness and quality of products developed; and
- Involvement of national-level agents in early stages of implementation in Borgou.

Contextual or Non-program Factors Affecting PMA/Nut

In a field program, there are usually outside factors that have an impact (positively or negatively) on the overall program. The Benin program was no exception. Below are factors that are believed to have had an impact on the PMA/Nut program:

- Benin's government enacted a decentralization policy that gave new and unprecedented power to the departmental level. This enactment was in operation at the very moment of the launching of PMA/Nut. To acknowledge and take advantage of this political change, the highest administrative departmental authority, the *Prefet*, led the process of PMA/Nut installation in Borgou.
- Working in a newly decentralized environment required clear parameters for reference. The memorandum of understanding (MOU) signed with the main stakeholder was an innovative approach for building partnership in Borgou. In addition to these stakeholders, other partnerships were developed with private voluntary organizations (PVOs) such as CRS,

Africare, and other bilateral projects funded by the Swiss and German governments. Local NGOs were also key partners in message dissemination.

Partnerships

Throughout the development and implementation of PMA/Nut, other sectors were actively brought into the program:

- Social workers from the Ministry of Social Affairs are a large group that carries out most nutrition work in the field. They were trained and equipped with the health workers.
- Journalists, communications specialists, and local radio personnel carried out most of the advocacy activities and message dissemination.
- Schoolchildren served as vehicles to reinforce messages at home.
- Agriculture extension workers contributed to key program activities (such as testing for iodized salt).
- Literacy agents were critical in translating messages into local languages.
- University of Benin Professors and students participated actively in the research phase, which laid the foundation for PMA/Nut.

- The project's short time span for external technical assistance catalyzed the DDS and expedited the scaling-up process in Borgou to ensure that the whole department shared all benefits.
- The Borgou department had the worst health and nutrition indicators. New Benin DHS survey data indicated that the nutritional status of women and children required greater emphasis in the health and nutrition programs at the country level.

Future Directions

PMA/Nut is at a very delicate moment in Benin. Thanks to the PMA/Nut approach, nutrition has become an important priority for the MOH and donors, although further advocacy such as the use of PROFILES is needed to link nutrition to mortality and productivity. The next phase for PMA/Nut is the implementation of the PMA/Nut platform throughout the entire country. This scale-up involves several challenges for the central MOH:

- The country is undergoing administrative decentralization in addition to decentralization within the public health sector. This means that departments and health zones will need to plan for PMA/Nut implementation, including the budgeting of resources. With the newly elected local government, there will be opportunities for advocacy and involvement in behavior change activities. The consensus workshop held in Parakou was a very important step, but now it is of paramount importance to follow up on the conclusions of the workshop and also to look critically at the next steps.
- Certainly the implementation of PMA/Nut should have an impact on other divisions of the MOH, like central medical stores. Various logistics assessments undertaken by PROSAF for the Borgou-Alibori department clearly show that stock-outs within the supply system have

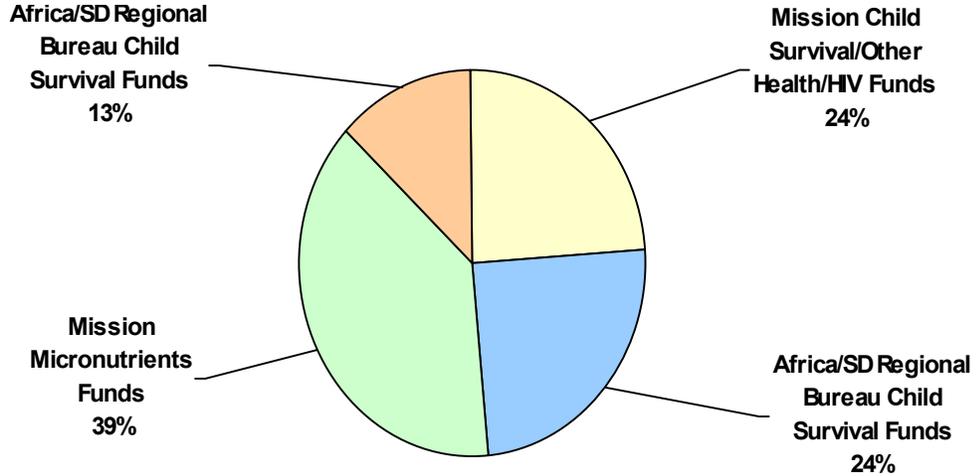
affected the quality of care. This could have an effect on anemia prophylaxis for pregnant women and children and the new vitamin A intervention.

- The supervisory system should be strengthened to ensure that the various nutrition actions are implemented correctly at the facility and community levels. Supervision can be one important mechanism for providing ongoing refresher training to help maintain health worker knowledge of the various elements of the PMA/Nut package.

In conclusion, the PMA/Nut experience has had a good start within the Borgou-Alibori department and the country should build on this positive experience to move forward.

6. USAID INVESTMENTS THROUGH BASICS II IN BENIN

**BASICS II Benin Program Expenditures
Life of Project by Funding Directive**



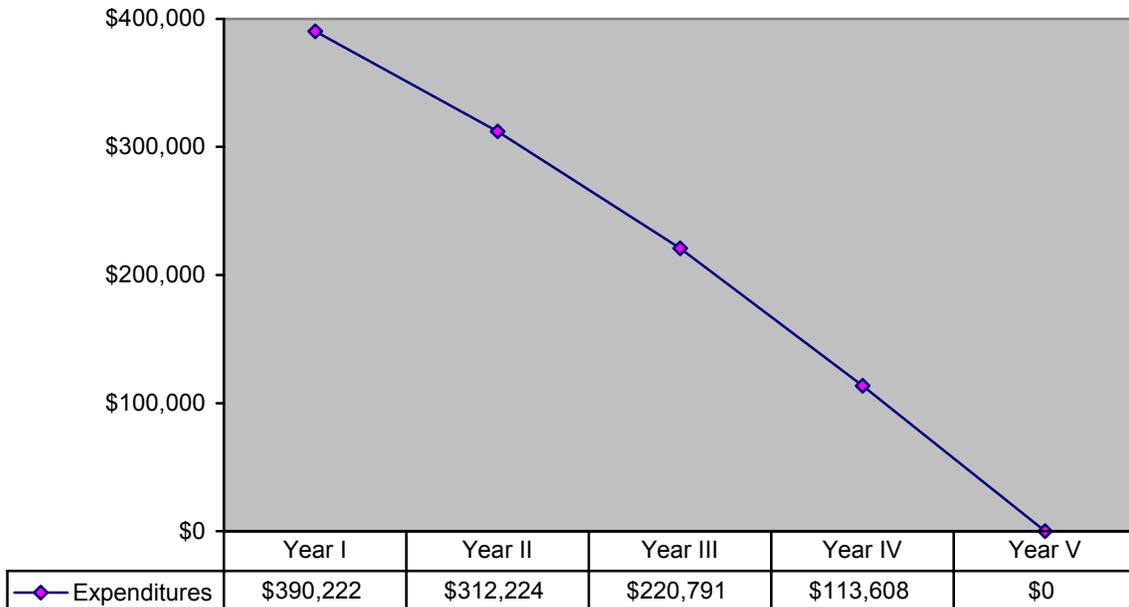
Total: \$1,036,845

**BASICS II Benin Program Expenditures
Life of Project by Funding Directive**

Funding Directive	Field Support Benin	Field Support Africa/SD Regional Bureau	Total BASICS II Benin Program Expenditures
Child Survival	\$250,000	\$252,446	\$502,446
Micro-Nutrients	\$400,000	\$134,399	\$534,399
Total	\$650,000	\$386,845	\$1,036,845

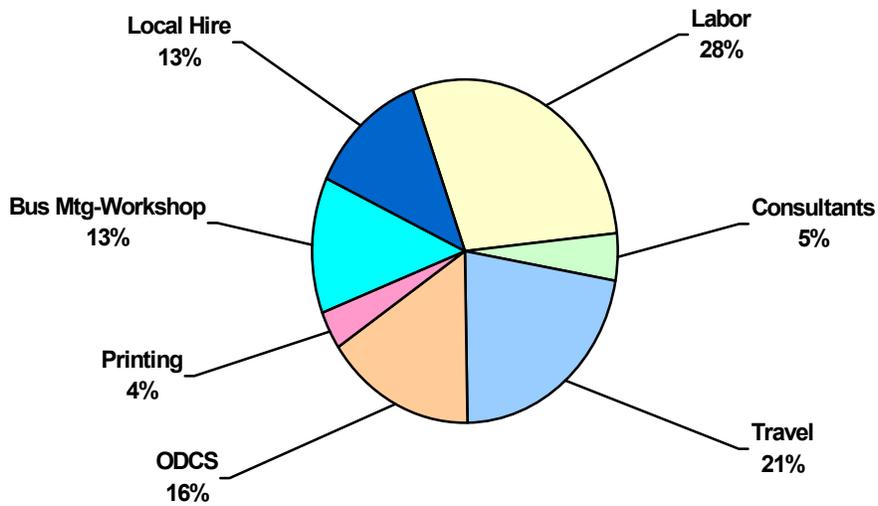
Total: \$1,036,845

**BASICS II Benin Program Expenditures
Life of Project by Year**



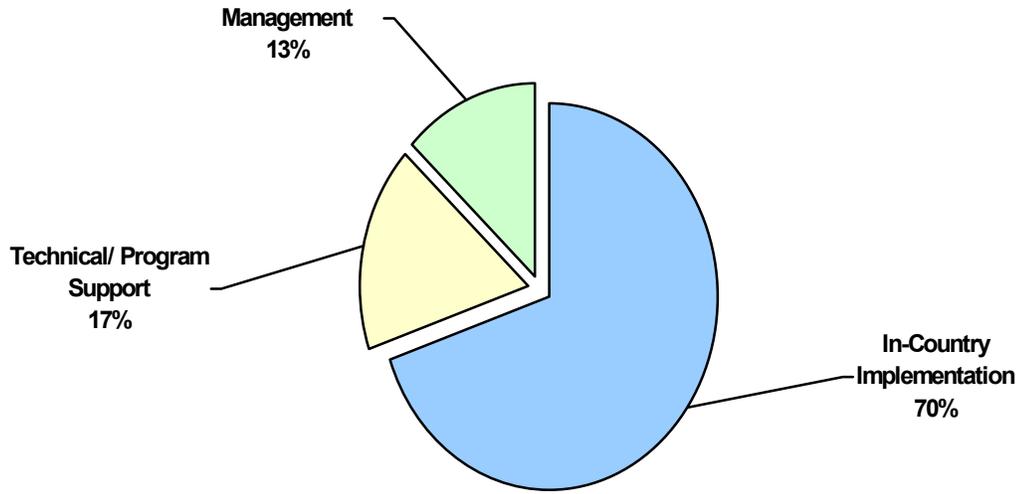
Total: \$1,036,845

**BASICS II Benin Program Expenditures
Life of Project by Account Category**



Total: \$1,036,845

**BASICS II Benin Program Expenditures
on In-Country Activities**



Total: \$1,036,845

DATA NOTES

1. The CRS survey was a standard 30 cluster survey in which each cluster (a village) was chosen from the whole CRS intervention area based on a Population Proportionate to Size (PPS) approach. The survey included 308 mothers whose children were 0–23 months old.
2. The PROSAF/CRS survey design was a two-level sampling. The first level was the choice of clusters (villages/communities) from a list of villages/communities in the PROSAF and CRS intervention areas. The second level was the random choice of the households.
3. The BASICS survey on communication was a household survey held in the pilot areas and in the non-pilot area.
4. The DHS (1996 and 2001) is a nationwide survey sponsored by USAID and other donors.

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ANNEX: Five-Year Program Overview

Category →	Project Year 1 →	Project Year 2 →	Project Year 3 →	Project Year 4 →	Project Year 5
	Mission Funded	Mission Funded	Potential regional and global	STTA and follow-up only	STTA and follow-up only
Best Technical Services	<p>Comprehensive CBC program and materials implemented in 4 districts to promote PMA/N</p> <p>Mass media and counseling cards used in 4 districts of Borgou to promote EBF, iron, and complementary feeding</p> <p>PMA/N implemented in all 14 districts of Borgou</p> <p>Evidence that exclusive breast feeding increases significantly (CRS, 40%, 1999) since 1996 DHS (19%)</p>	<p>CBC program intensified in 10 non-pilot districts to include all CBC materials and media</p> <p>New messages and tools on routine Vit A & iodized salt produced and diffused</p> <p>60% Vit A coverage in Borgou achieved through NIDs and routine services.</p> <p>Exclusive breast feeding increased significantly in Borgou</p>	<p>Active Learning Centers developed with IRSP and WARO TA</p> <p>PMA/N SET to other districts in Benin (workshop)</p> <p>Mini-survey of Vit A coverage</p>	<p>PMA/N Materials adapted as appropriate for other districts</p> <p>60% Vit A coverage in Borgou through NIDs sustained and 50% 2nd dose coverage through routine achieved.</p> <p>Exclusive breast feeding increase sustained at SO levels in Borgou.</p>	<p>Transfer of best practices to other districts, nationally, regionally</p>

Category →	Project Year 1 →	Project Year 2 →	Project Year 3 →	Project Year 4 →	Project Year 5
Systems Strengthening	<p>Knowledge assessment of PMA/N messages at HH level (Quantitative study in 4 pilot districts vs 4 other districts)</p> <p>PMA/N implementation review at HF level in the 4 pilot districts vs 4 other districts in Borgou</p>	<p>System for routine supply of Vit A in place at national, regional (Borgou) and district level and regional Vit A Days organized.</p> <p>Assess, review and strengthen management & supervision system at HF level in 14 districts and develop a monitoring / evaluation plan</p>	<p>PMA/N routine monitoring and supervision strengthened at health facility level in all 14 districts.</p>	<p>PMA/N expanded to additional districts outside Borgou.</p> <p>Management of BASICS Program (PMA/N) transferred to DDSP (and PROSAF)</p>	
Community Mobilization	<p>Support for PMA/N generated at all levels of MOH and with other partners</p> <p>Expansion of MinPak flipcharts into non-pilot districts and other regions of Benin supported by World Bank “Projet Santé Population”</p>	<p>14 districts trained in community approaches and programs</p> <p>Community programs implemented throughout Borgou with emphasis on Vit A and breast feeding</p>	<p>PMA/N Community Component expanded to other regions</p> <p>Other child health interventions build upon PMA/N community approach in Borgou</p>	<p>PMA/N Community Component continues to be expanded to other regions</p> <p>Other child health interventions continue to build upon PMA/N community approach in Borgou</p>	

Category →	Project Year 1 →	Project Year 2 →	Project Year 3 →	Project Year 4 →	Project Year 5
Advocacy	<p>Advocate for better policy and systems for Vit. A distribution</p> <p>Begin documentation of Benin PMA/N experience with SET Dakar</p>	<p>Policies and systems for routine distribution of vitamin A strengthened (MOH/UNICEF)</p> <p>Increase ownership of PMA/N approaches and strategies among MOH, PROSAF and other partners</p> <p>Organize a PROFILES session and continue documentation of Benin PMA/N experience</p>	<p>Advocate at MOH for expansion of PMA/N to other regions</p> <p>IRSP supported at national and regional levels</p>		