



Healthy Savings for Better Reproductive Health in Bénin
Final Program Report
February 2019

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Association pour la Promotion de l'Homme, la Protection de l'Environnement pour un Développement Durable (APHEDD)

APHEDD is a non-governmental organization formed by a group of men and women concerned about the living conditions and livelihoods of grassroots communities and the political, economic and social development of Africa, in general, and Bénin, in particular. Its mission is to help raise the living standards of grassroots communities by providing access to information, education, training and research thereby empowering action for self-promotion by 2025. Initiatives are focused on and include literacy, education, health, food security, access to financial services, land and housing.

Femmes Actrices de Développement Communautaire (FADeC)

FADeC is a non-governmental organization formed by a group of women concerned about women's contribution to poverty reduction and grassroots development. While working for EDUCOM (Education and Community), this group of women created FADeC with support from UNICEF. FADeC's mission is to support communities in solving their development problems, with particular emphasis on children's education, specifically access and retention of girls in school and completing their education. Other areas of focus include women's rights, health and environment.

Grameen Foundation

Grameen Foundation is a global nonprofit organization that helps the world's poorest people achieve their full potential by providing access to essential financial services and information on health and agriculture that can transform their lives. In 2016, Grameen Foundation and the global nonprofit [Freedom from Hunger](#) decided to join forces under the banner of Grameen Foundation. The integration of the two organizations brings together Grameen Foundation's expertise in digital innovation to end poverty and Freedom from Hunger's focus on providing the world's poorest women with self-help tools to reduce hunger and poverty. Grameen Foundation is headquartered in Washington, D.C., with offices in the U.S., Asia, Africa, and Latin America. For more information, please visit www.grameenfoundation.org or follow us on Twitter: @GrameenFdn.



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We would also like to voice our appreciation for the Keith Kiernan Foundation, ABC Foundation, Lalor Foundation, Tsadik Foundation, Tom Des Brisay and the Toole Charitable Fund for supporting this project.

Finally, we would like to voice our appreciation for the community agents who collected the data for this report and provided support to the local women's savings groups and the savings group members who gave of their time.



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Acronyms

APHEDD	Association pour la Promotion de l'Homme, la Protection de l'Environnement pour un Développement Durable
CA	Community Agent
FCFA	West African Franc
FADeC	Femmes Actrices de Développement Communautaire
FSP	Financial Service Provider
FP	Family Planning
HH	Households
IPL	International Poverty Line
IUD	Intrauterine Device
NGO	Non-governmental organization
NPL	National Poverty Line
PLC	Pictorial Learning Conversation
PPI	Poverty Probability Index
SG	Savings Group
SIS	Social Indicator System



Healthy Savings for Better Reproductive Health in Bénin
Project Overview

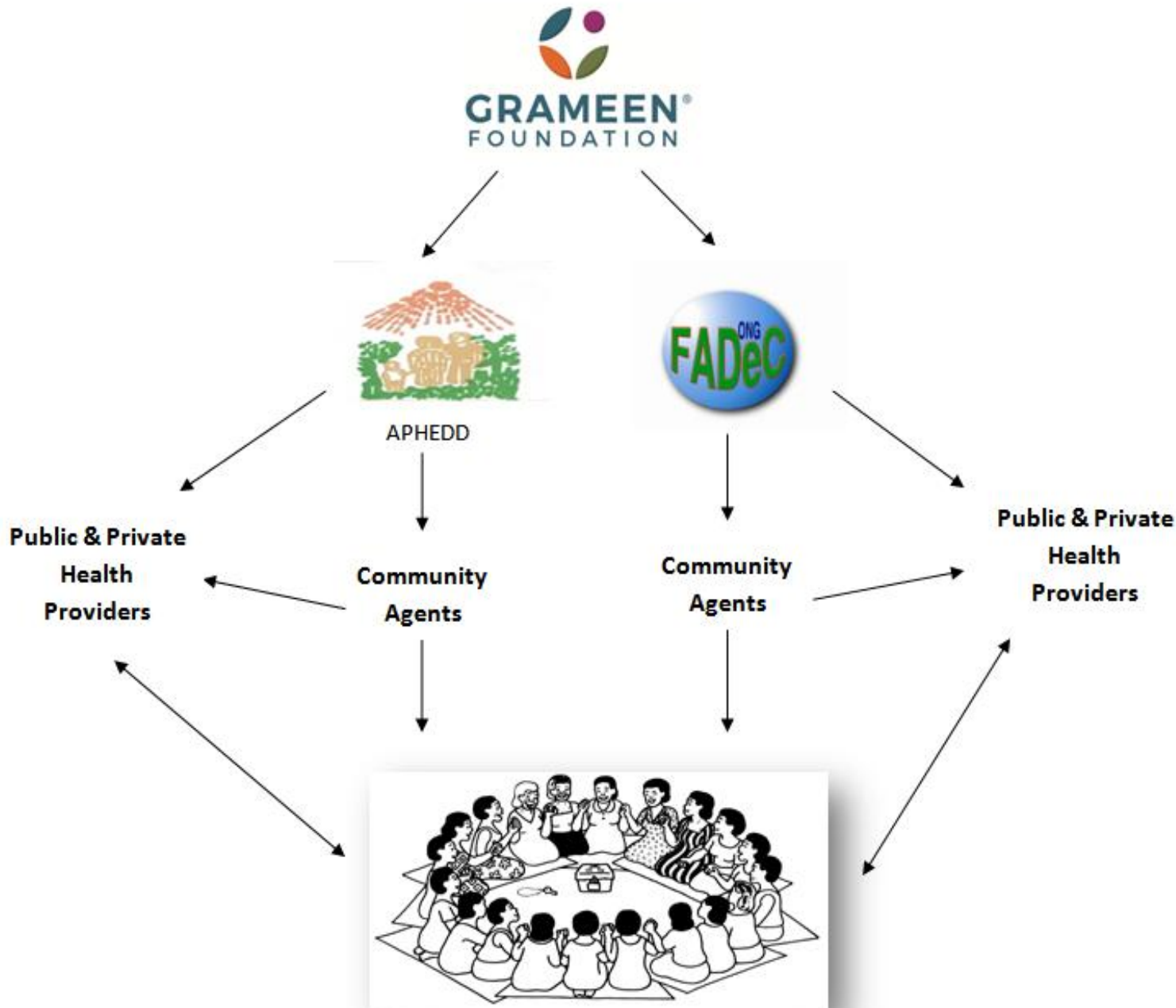
Women's Savings Groups for Better Reproductive Health in Bénin

Since 2013, Freedom from Hunger, now Grameen Foundation, has been privileged to work in partnership with two local non-governmental organization (NGO) partners in Bénin – APHEDD (Association pour la Promotion de l'Homme, la Protection de l'Environnement pour un Développement Durable) and FADeC (Femmes Actrices de Développement Communautaire) – in the development of their **Healthy Savings** program. The objective of this program initially was to introduce and train partners on Grameen's savings group (SG) methodology, and then subsequently to plan, develop and pilot a health intervention package to improve access to health services for 3,000 SG members and families. In 2015, as a result of the intervention, over 15,000 SG members had access to health services through negotiated benefits with 43 public and private health providers.

The women who participated in the **Healthy Savings** program reported interest in seeking information about family planning products and services. In response to this request and the enormous unmet need for family planning in the region, Grameen Foundation has worked closely with APHEDD and FADeC to integrate a family planning approach to their existing SG program. This new project, called **Women's Savings Groups for Better Reproductive Health in Bénin**, seeks to both complement and strengthen Bénin's national family planning strategy and contribute to achieving the longer-term goal of increasing the contraceptive prevalence rate among women.



Linkage and Sustainability Model



- Grameen Foundation works with local NGO partners APHEDD and FADeC to design the program, linkages and products, and build staff capacity for implementation
- Local NGOs train volunteer Community Agents (who live in the villages) to deliver Family Planning education, along with the health savings methodology and health provider linkage information, to women's Savings Groups
- Public and private health provider linkages with the local NGOs extend to the Community Agents and groups

Savings Groups + Health Savings

516 savings groups incorporated health savings into their groups, providing women and their households with access to health loans and an annual savings payout earmarked for health expenses.

29,514,800 CFA has been collected for health savings as of December 2018 (51,152 USD)*

Family Planning Education

11,590 women in **516** savings groups received family planning education.

Gender Dialogues

44 Gender dialogues conducted with **1,624** women and **593** men.

*1 Dollar (USD) = 577 West African CFA franc as of February 2019



Overview

Women’s Savings Groups for Better Reproductive Health in Bénin

Why Family Planning?



At least one out of every three married or in-union women in Bénin is not using any form of contraception, even though she reports that she wants to delay or avoid pregnancy.¹ In addition, the use of modern methods of birth control is very low in Bénin. According to Family Planning 2020, a global partnership invested in rights-based family planning, Bénin has made considerable progress since 2012 when the rates of modern contraception were below 10%. The most recent projections show rates climbing to 15% of married women and 17.1% of all women by 2020 - still short of the 20% goal that the country established in 2012.²

While the Bénin government continues to invest in and promote family planning, many gaps remain at the community level. The goal of **Women's Savings Groups for Better Reproductive Health in Bénin** is to advance opportunities for rural women and their husbands to make choices about their sexual and reproductive health that best fit their individual needs and those of their families. The achievement of this goal will help women and couples achieve their desired family size, allow more Béninese the opportunity to live healthier and more productive lives, improve survival and well-being among their children, and contribute to economic and social development.

The strategies for achieving this goal include:

1. Increasing knowledge of family planning and access to local health services for contraceptive services; and
2. Addressing gender and other social barriers to contraception use

¹United Nations, Department of Economic and Social Affairs, Population Division (2017). World Contraceptive Use 2017 (POP/DB/CP/Rev2017).

²<https://www.familyplanning2020.org/benin>

Program Components and Desired Outcomes



The primary components of the program work together to address the demand-side of family planning by building a supportive environment for recommended family planning practices and influencing knowledge, attitudes, intentions and behaviors related to family planning. **The primary components of the program and desired outcomes are as follows:**

Savings Groups + Health Savings

- Outcome 1: Increase in health savings to support treatment-seeking behaviors

Family Planning Education and Linkages to Health Providers

- Outcome 2: Improved knowledge of family planning methods and benefits
- Outcome 3: Improved attitudes towards family planning

Gender Dialogues

- Outcome 4: Increased dialogue with spouses and health providers regarding family planning

Savings Groups + Health Savings

Savings groups that have been saving regularly for nearly a year were given the option to incorporate a separate health savings (in addition to their regular savings) to set aside money only for health-related expenses. Research has shown that earmarking savings for health is successful for savings groups in that it prevents the cash from being used for unplanned expenses such as transfers to a family member or luxury spending, and it increases the ability to cope with shocks.¹

From the pooled health savings, the groups are able to grant members health loans when health issues arise. Groups follow the same methodology and process for approving health loans as they do for regular loans, but groups may meet to approve a health loan in an emergency.

Health savings are disbursed at the end of the cycle, just as the regular savings are. Groups have the opportunity to do what they wish with this cash.

¹[Dupas, Pascaline; Robinson, J. Why Don't the Poor Save More? Evidence from Health Savings Experiments](#)



Family Planning Education



The family planning education component of the **Women's Savings Groups for Better Reproductive Health in Bénin** project involved the design and delivery of six dialogue-based education sessions called *Planning Your Family: It's Your Decision*. These education sessions were designed to be delivered through pictures called pictorial learning conversations (PLCs) delivered consecutively during the women's savings groups' regularly planned meetings and engage women and community members in participatory dialogue. The PLC methodology is designed to be delivered by community agents (CA) who are illiterate or have minimal literacy. CAs are trained members of *Saving for Change*¹ SGs who form other SGs in their own community or in nearby communities to provide education to members on relevant health and other topics.

The *Planning Your Family: It's Your Decision* PLC was designed after extensive desk research, a landscape analysis and community sensitization meetings which complemented experience and understanding of family planning within the local context. The initial draft of the PLCs then went through a field-testing process which included focus group discussions (FGDs) and individual interviews with partner NGO staff, CAs and women's SGs. A Trainer's Guide and a Facilitator's Guide were also developed which enable cascade training and encourage replication, quality of delivery, and scale of the PLC.

The specific objectives of the PLCs are to enable the SG members to:

1. Identify reasons why planning for their family and future is advantageous for household health and economics.
2. Describe products and tools, including locally-available contraceptives and health loans that allow women and their husbands to plan for their family and future.
3. Discuss challenges related to take-up of family planning practices and behaviors, including side effects, community stigma and marital relationships.

¹*Saving for Change* is a methodology jointly developed by Freedom from Hunger, Oxfam America and Strømme Foundation for self-managed savings and lending groups integrated with simple trainings in health, business and money management.

Family Planning Education - Community Agent



Rose

Rose is a community agent (CA) and was trained to deliver family planning education to her savings groups. Although it is a sensitive topic in the community, Rose sees a great need for family planning. She feels particularly passionate about sharing this information for both the health and happiness of others in her village. In addition to her role as a CA, Rose has her own beauty shop. She sees that women visit her in this safe space, and trust her. *"I'm a hairdresser and people come to me. So I take advantage and talk to them about family planning."* She keeps her family planning education guide in her shop to have on-hand when clients come to get their hair and nails done. *"I have the picture cards in my beauty workshop and people ask about them and I explain. Even one woman sent her husband to me and I explained it to him."* Rose is proud to go above and beyond her role as a CA.

-End of Project Monitoring Assessment

Linkages to Health Providers

Linkages with local health providers was a core aspect of the ***Healthy Savings for Reproductive Health in Bénin*** project in order to:

- Facilitate or improve access to health services for SG members
- Improve the quality and reach of those services
- Advocate for the promotion of community-based access to family planning, including modern contraceptives, through work with local and national government.

FADeC and APHEDD were instrumental in building the capacity, awareness and connection between community agents (CA), government officials, local health providers and savings group (SG) members. They addressed both demand and supply issues with the CA through advocacy on behalf of the SG members and providing training.

“Women come in more willing for family planning now. Before they were reluctant because of side effects and their husbands did not approve. But they want more time before they become pregnant again.”

“They pay easily because it seems they have a bag they can get a loan from. So they can pay easily the fees.”

“The partnership with APHEDD brings more patients to me. If I have more patients I have more resources and I can improve the health clinic. As you can see I have improved the health clinic.” (Le Jourdain)

-Health Providers, End of Project Monitoring Assessment



Gender Dialogues



From the initial landscape analysis that was conducted at the beginning of the project, it was clear that men needed to be involved if the project was going to be successful.

“Family Planning is the new generation talk. Health workers have some strategies and they inform the couples to take decisions. I don’t like the topic. It opens the door to prostitution for the young generation.

Family planning is a means to stop giving birth.”

- Husband of SG member quoted during the landscape assessment.

The men were invited to the final family planning education session and were invited to talk to their wives about future plans and desired number of children. In addition, once the family planning sessions were completed, they were invited to participate in gender dialogues, facilitated by a skilled, literate facilitator to address the deeply-held social and gender norms around family planning.

The gender dialogues were designed, taking into consideration existing resources and Grameen’s formative research results, and then tested in several villages. The gender dialogues consist of two skits and one story which address different family planning challenges, following characters representative (but not personal and non-threatening) of typical “men”, “mothers-in-law”, etc. who live in rural Beninese villages. With support from the local NGO facilitators, Savings Group members practiced and acted out the skits, which were received warmly and with laughs and engagement from audience members which included SG members, their husbands, community leaders, religious leaders and others from the village. Each 5 minute skit/story was followed by discussion questions for the group.

“The discussions about family planning started with women’s groups. Then it progressed and they invited us. We didn’t understand before, but now understand after the conversations. We were sleeping and they woke us up.”

- Husband of SG member quoted during the end of project monitoring assessment.

Assessing the role of the health savings and loan component against Outcome 1 (increase in health savings to support treatment-seeking behaviors) the project found:

Health Savings Attitudes

- Increased confidence in coming up with emergency funds and that these funds could come from savings group funds
- No change in confidence in covering health costs

Health Saving Behaviors

- Increased average weekly group savings
- Increased average weekly health savings
- No change in health loan use
- Increased average size of health loan used
- Health loans were reported to cover a smaller portion of the total medical expense
- Increased use of personal savings to cover expenses where health loans fell short
- Reported savings group use for health expenses remained low



Savings Groups + Health Savings: Key Findings

Assessing the role of the health education and community dialogues against Outcome 2 (improved knowledge of family planning methods and benefits); Outcome 3 (improved attitudes towards family planning); and Outcome 4 (increased dialogue with spouses and health providers regarding family planning), the project found:

Family Planning Knowledge and Attitudes

- Increased awareness and satisfaction of health providers promoted by APHEDD and FADeC
- Increased reports that pregnancy with youngest child was desired
- Increased perception of positive well-being
- Decreased reporting of “I don’t understand the methods” as a reason for *not* using FP methods

Family Planning Behavior

- Increased use of health providers promoted by APHEDD and FADeC
- Increased discussions between women and health professionals about family planning methods in last 6 months
- Increased communication with husband about:
 - how many children to have
 - child spacing
 - family planning methods
- Increased use of contraceptives

Decision Making Power

- Increased reporting among FADeC clients that family planning is a joint decision



Family Planning Education and Gender Dialogues: Key Findings

Despite the overall positive project results, some challenges remain for consideration and possibly for future project revision or replication:

Family Planning Knowledge

- Despite fewer reports of “I don’t understand the methods” as a reason for not using contraception at baseline, fear of side effects continued to be the most common reason given for not using a contraceptive method by endline.

Health Savings

- Low usage of health loans overall. Low usage translates into less interest earned on group funds for members and also raises questions about the responsiveness of the loan in covering health costs. While the group members have expressed a high degree of satisfaction with the health savings, its design features should be explored in order to further understand use preferences that could be addressed to better meet the needs of group members.

Decision Making Power & Domestic Violence

- Fewer FADeC clients at the endline reported that family planning was a joint decision. This is likely attributed to a change in perception about the role a husband plays in the decision.
- While the project didn’t directly try to address domestic violence, the survey data suggests there was no change in beliefs that husbands are not justified in beating their wives nor a change in how often women felt fearful of husband.



Challenges



Healthy Savings for Better Reproductive Health in Bénin

Client Outcome Endline Evaluation & Monitoring Assessment Findings

Introduction

Under the *Women's Savings Groups for Better Reproductive Health in Bénin*, research, evaluation and monitoring (REM) activities, primarily in the form of a baseline, endline and monitoring assessment, have played a key role in helping the project stakeholders to understand changes in knowledge, attitudes and practices associated with use of group-based savings, health savings and loans, health provider linkages and gender dialogues regarding family planning practices as well as PLCs on family planning implemented with women's SGs.



Methods

The client outcomes study includes a simple baseline and endline methodology conducted with project participants capturing knowledge, attitude and behavior change prior to program implementation and after implementation. A quantitative survey was designed by Grameen Foundation, consisting of approximately 76 questions, divided into five sections: 1) respondent information; 2) savings indicators; 3) health services and family planning indicators; 4) household indicators (including poverty level indicators); and 5) food security.

The survey was implemented using Grameen's Social Indicator System (SIS), which includes a monitoring system managed by NGO or financial service provider (FSP) staff that emphasizes the collection of socially-oriented indicators of SG members (in contrast to group financial indicators typically collected by the monitoring information system (MIS), while building the capacity of NGO or financial service provider (FSP) staff in monitoring and evaluation. Grameen Foundation staff trained facilitators at APHEDD and FADeC in October 2017 to collect the data using a digital survey tool called SurveyToGo and Grameen conducted analysis of the data.

As a way to ease the burden of cost, time and effort of data collection on NGO staff, the client outcomes study follows the SIS sampling strategy: all facilitators interview one randomly selected SG member from the first group formed by each CA that they manage at the time of the baseline. Facilitators use "drawing the short stick" or similar method at a group meeting to publicly and randomly select a participant for surveying. Women are not required to participate, and data is kept confidential.

A total of 204 SG members participated in the baseline survey which included 104 women among FADeC's members and 100 women among APHEDD's members. The baseline survey occurred in November 2017 prior to the delivery of the *Planning Your Family: It's Your Decision* education sessions. The endline data was collected in November of 2018 among the same participants who participated in the baseline, resulting in 104 women among FADeC's members and 99 women among APHEDD's members. This represents a 99% retention rate among survey participants.

This final client outcomes report presents the key findings from both the baseline and endline assessments as well as a project-end qualitative monitoring assessment to determine the effectiveness of the family planning education, linkages and gender dialogues in improving knowledge and behaviors related to family planning. For the monitoring assessment, key stakeholders, including savings group members, men who participated in the gender dialogues, NGO partner staff and health provider partners were interviewed via focus group discussions and/or individual interviews. This evaluation method does not produce a rigorous or scientific representation of all the groups but the sample size is seen as providing an adequate example of the groups. In addition, the data was collected by FADeC and APHEDD staff and there is no counterfactual group. However, client outcomes assessments are useful tools in helping partners understand whether the education and tools that they provide beneficiaries are resulting in improved knowledge, attitudes and behaviors.

Who is an Average Survey Participant?

- She is 34 years old
- She is in a monogamous marriage
- She is raising more than 4 children
- She is illiterate
- She lives in a rural community
- She reports that she is generally “pretty happy” and is in “very good” health
- She has been a member of her SG between two and six years
- Her SG has distributed funds between five and six times
- She lives under \$2.50 per day
- She is food insecure

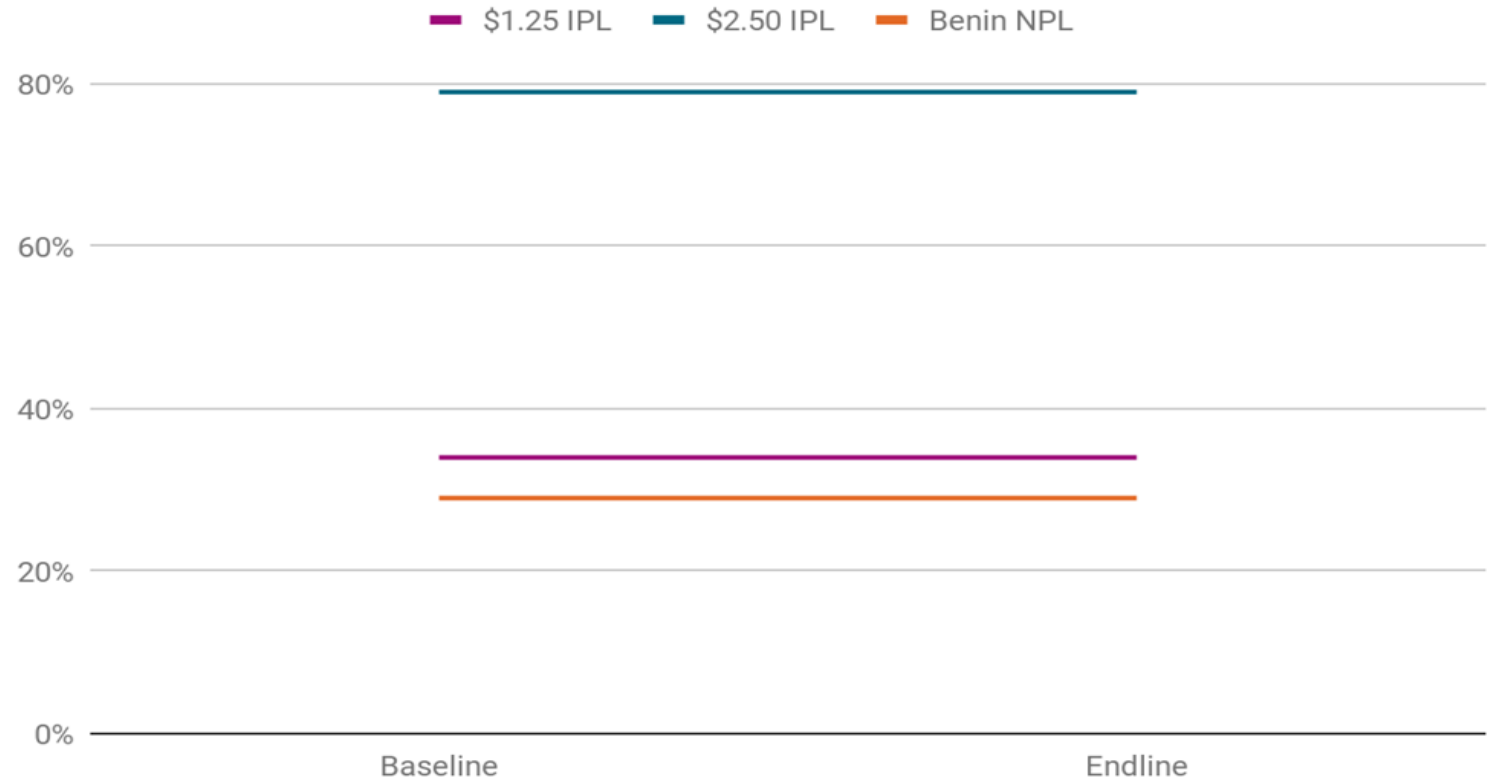


Moulikatou is a mother of four children. After learning about family planning she talked with her husband and took a health loan of 10,000 CFA from her savings group to visit a clinic. The loan paid for her transportation and for an intrauterine device (IUD). *“When I received information before, even on the radio, I was interested but they didn’t say to talk to your husband. I was scared something in the procedure would go wrong and then he would find out. I liked that here I was encouraged to talk to my husband about it. So I did. And he immediately accepted. I now tell my close friends about my experience and how I didn’t even have side effects.”*

Poverty Profile

Not only is the poverty profile of FADEC and APHEDD's clients very similar to each other, the poverty probability index remained virtually unchanged from baseline to endline, with just under 80% of the clients living below \$2.50 per day, and over one third living under \$1.25 per day.

Given the one-year project implementation period, poverty status was not expected to change, but this metric is helpful for understanding poverty outreach.

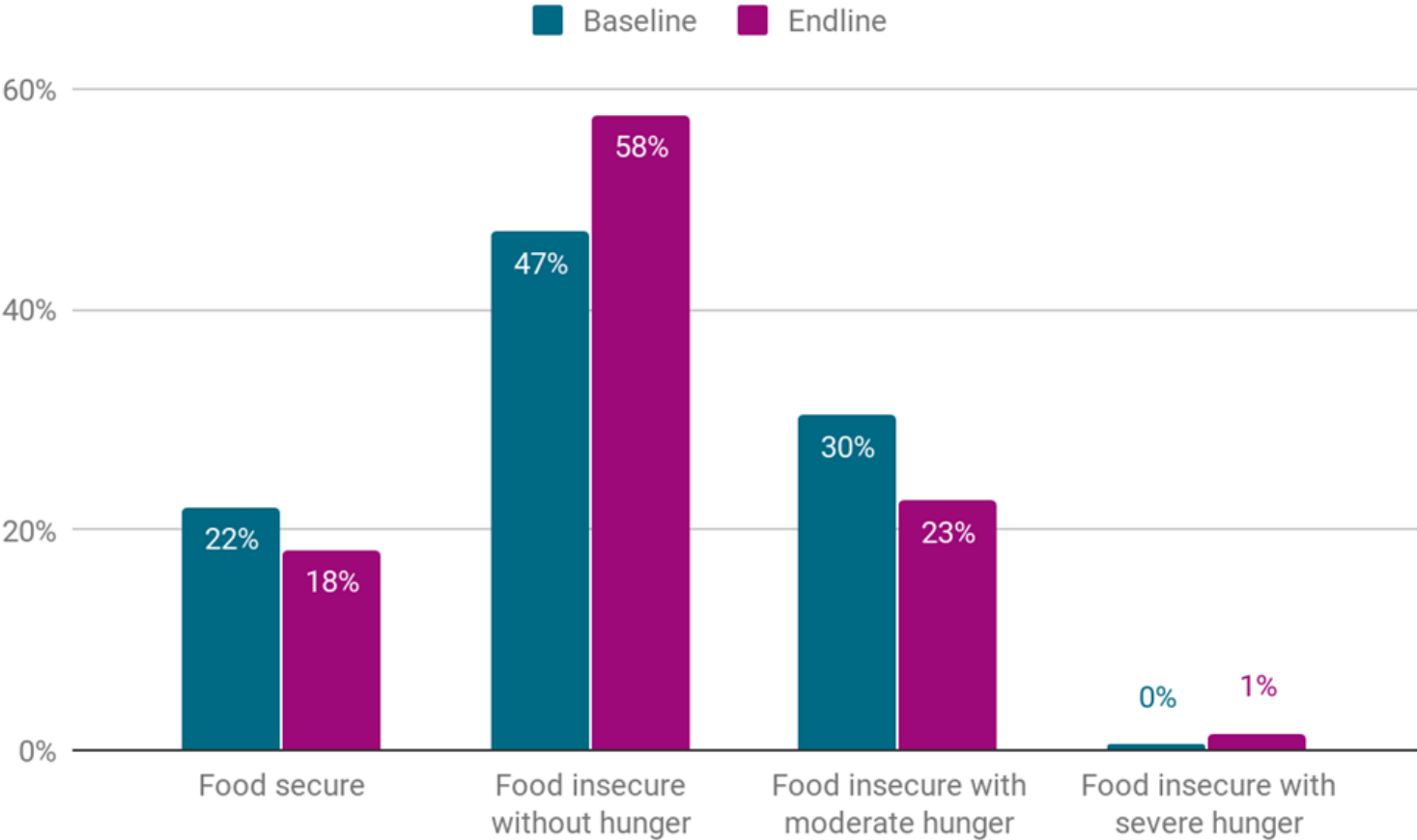


The national poverty line (NPL) for Benin, the International Poverty Line (IPL) \$1.25/day and the IPL \$2.50/day indices were constructed in 2012 using 2010 values from the Benin Poverty Probability Index (PPI) Scorecard. Raw values were generated based on responses, summed, and then matched with probability ranges using PPI documentation. A limitation of this research is that the sample size of the survey is very small and as a result, the results of the PPI analysis are simply suggestive of a likely poverty rate for the respondents. A defined level of confidence in the likelihood that the survey respondents live below various poverty lines would require a much larger sample size.

Food Security Profile

To measure food security, participants were asked to choose among four statements that would best describe their household in the last 12 months: had enough to eat of the nutritious foods they wanted (food secure), had enough food but not always nutritious (food insecure without hunger), sometimes not enough food to eat and was sometimes hungry (food insecure with moderate hunger), often not enough food to eat, was often hungry (food insecure with severe hunger).

Food security tends to cluster around “Food insecure without hunger” but a still relatively large group of FADeC and APHEDD clients face food insecurity with moderate hunger. This indicates the majority of clients face some degree of food insecurity (approximately 80 percent).





Savings Groups + Health Savings

Outcome 1: Increase in health savings to support treatment-seeking behaviors

Health Loan Use



Estelle

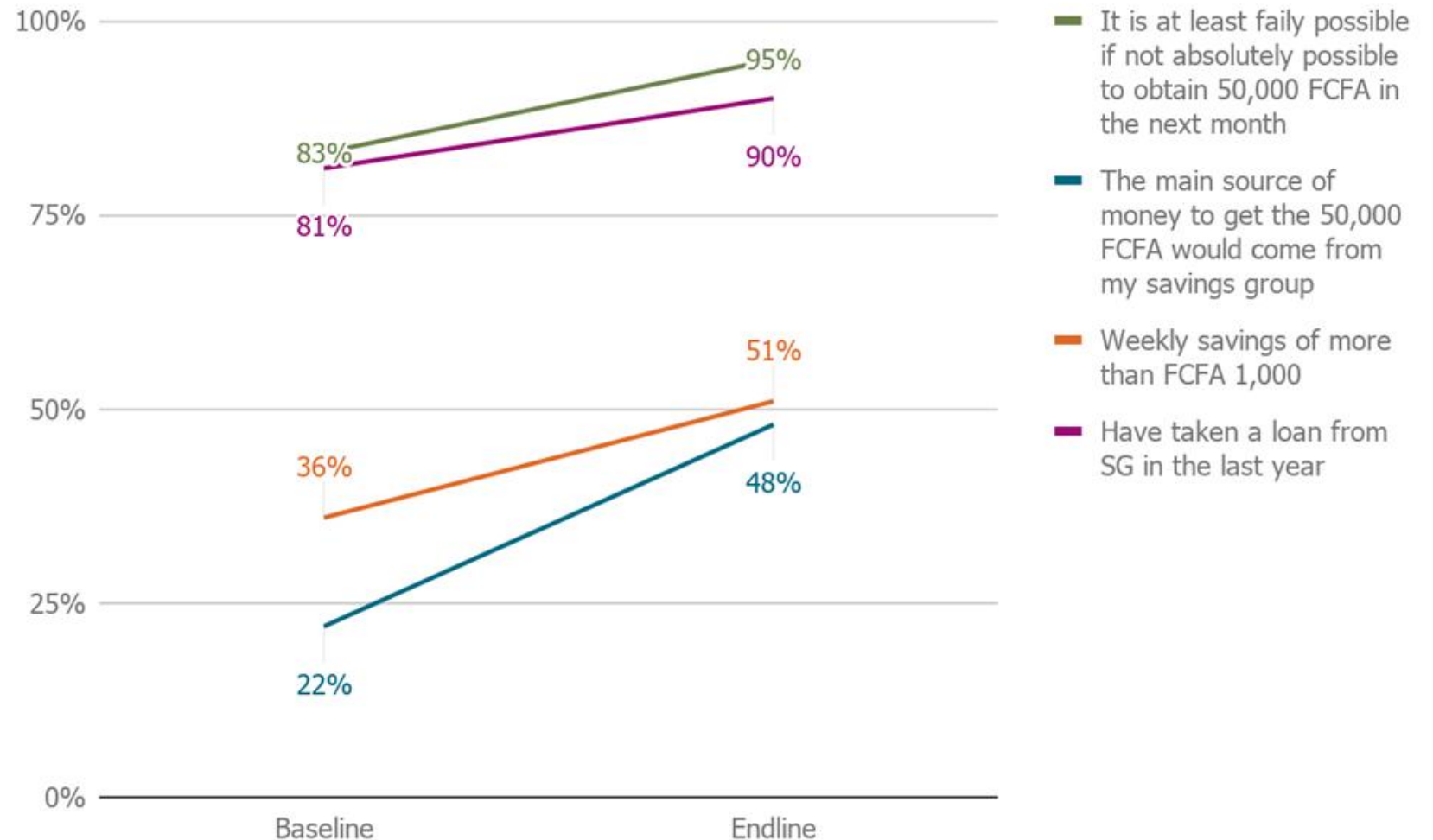
While receiving the education sessions from her CA, Estelle introduced the topic of family planning with her husband and shared information with him along the way. She was disappointed by his initial reaction; he refused to accept that family planning could be positive, in part because he feared contraceptives would create health problems. However, Estelle continued to share what she learned during her SG sessions and discussions. Finally she convinced him to let her give it a try. Estelle and her husband did not have the extra cash on hand that was needed for the visit, so she took out a 10,000 CFA health loan from her SG. She and her husband then travelled on his motorbike together to the local health center. The nurse took a blood test and they discussed what might be the best method to try. She and her husband learned that there were no side effects from the contraceptive. Estelle stated, *“I was so happy with this information. I already have three children. I had heard of family planning, but we didn’t trust the people who gave us the information because we didn’t know them. We feared it was risky. In this context, the way we received the information gave us confidence to try.”*

-End of Project Monitoring Assessment

Group Savings Behavior

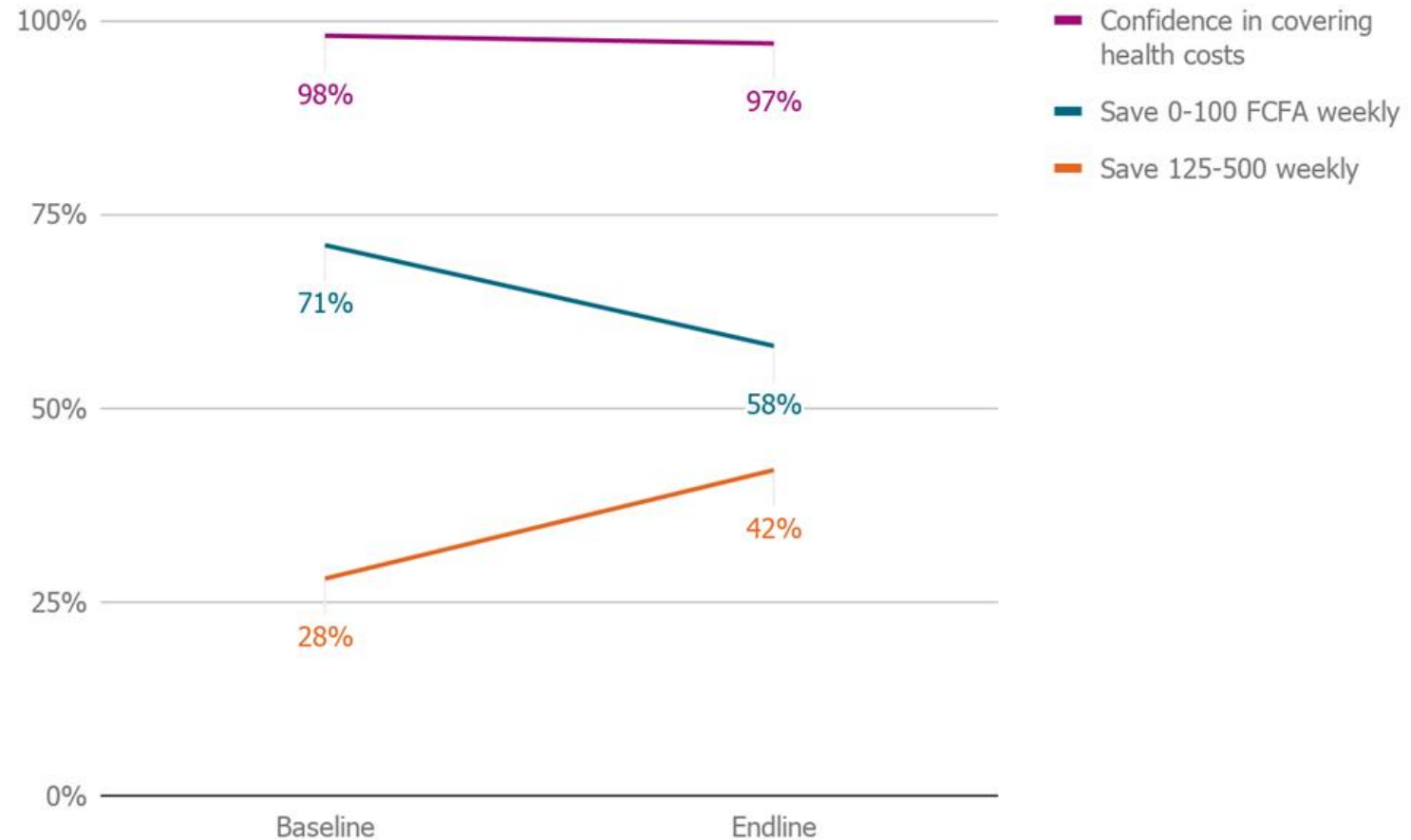
- Confidence in coming up with 50,000 FCFA¹ in the next month increased.
- More report that these funds would come from SG funds and personal savings as opposed to money earned while working and/or family or friends as reported at baseline.
- Weekly reported savings amounts increased as did the the number of women who reported taking out a loan
- Reports of a 2% interest rate remained the same from baseline.

¹Lum sum amount established by Global Findex study considered to be a typical emergency cost.



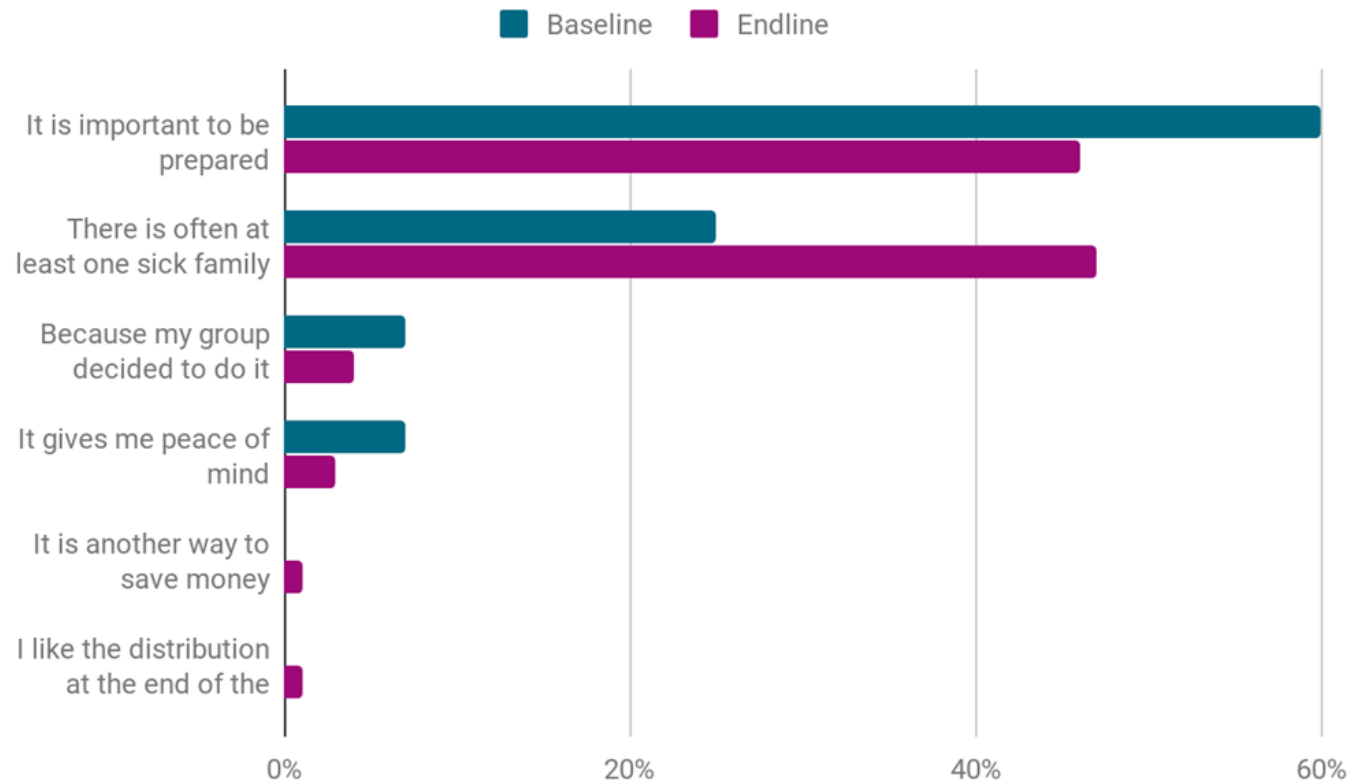
Health Savings Behavior

- 99% reported that they have a health savings fund as opposed to 100% at baseline (3 women said that their groups did not have a health fund).
- Savings funds distributed one more cycle since baseline.
- Confidence in covering health costs remained virtually unchanged.
- The amount of weekly health savings increased.
- Whether SG members would recommend others have a health fund decreased very minimally (from 100% at baseline to 98% at endline).



Why Save for Health?

The majority of the women reported that they use the distributed health funds for household goods. This remained unchanged from baseline. There was however a shift in *why* they reported they save for health. By endline more reasons were given overall and more women reported that it was because there is often one sick family member.



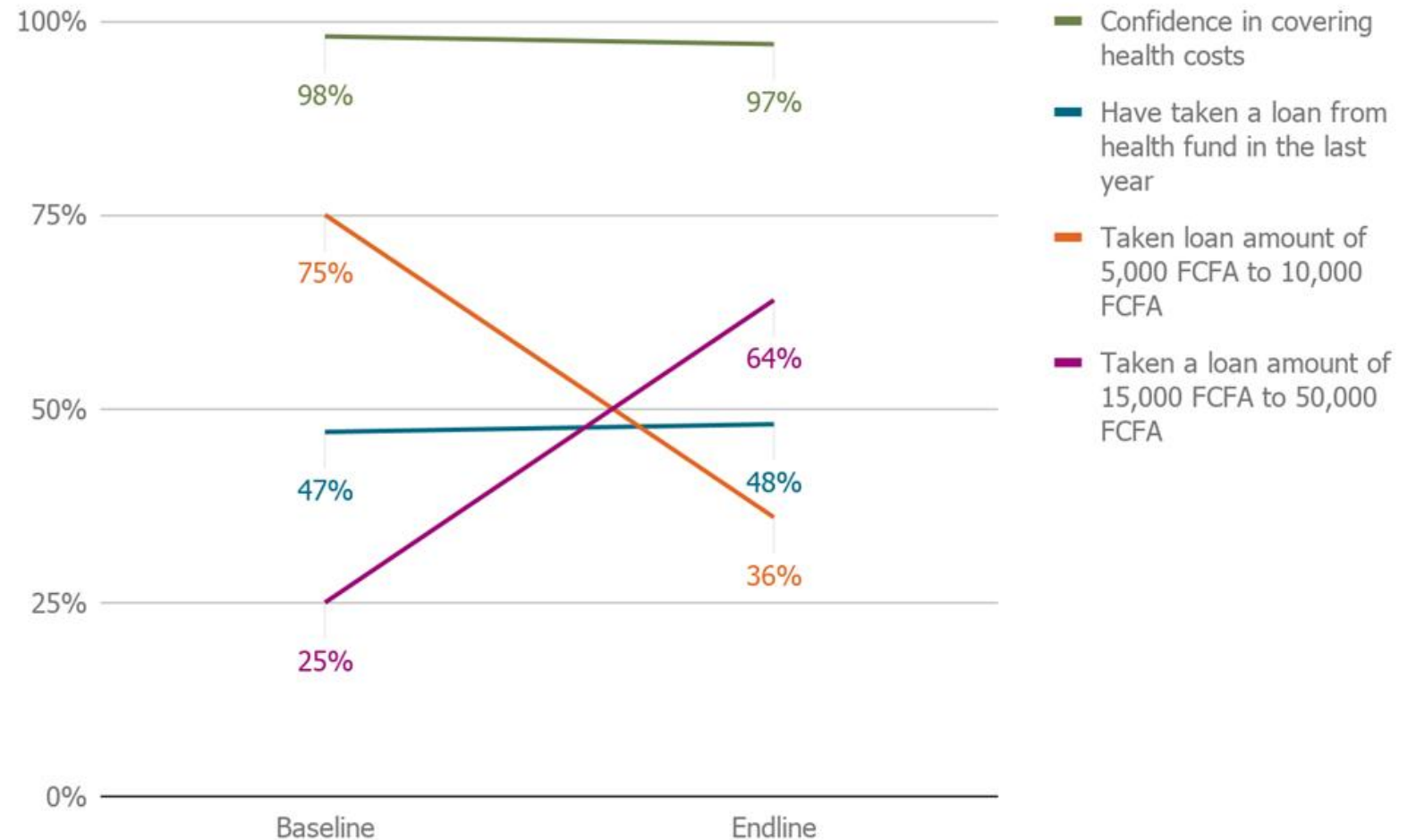
Health Loan Use

- The reported interest rate remained consistent from baseline to endline at 1%.
- Health loan use remained virtually unchanged over baseline.
- Of the health loans taken out since baseline, the reported loan amounts increased.

“If you are pregnant and at the hospital you can even ask the group to bring health savings to the hospital to help you.”

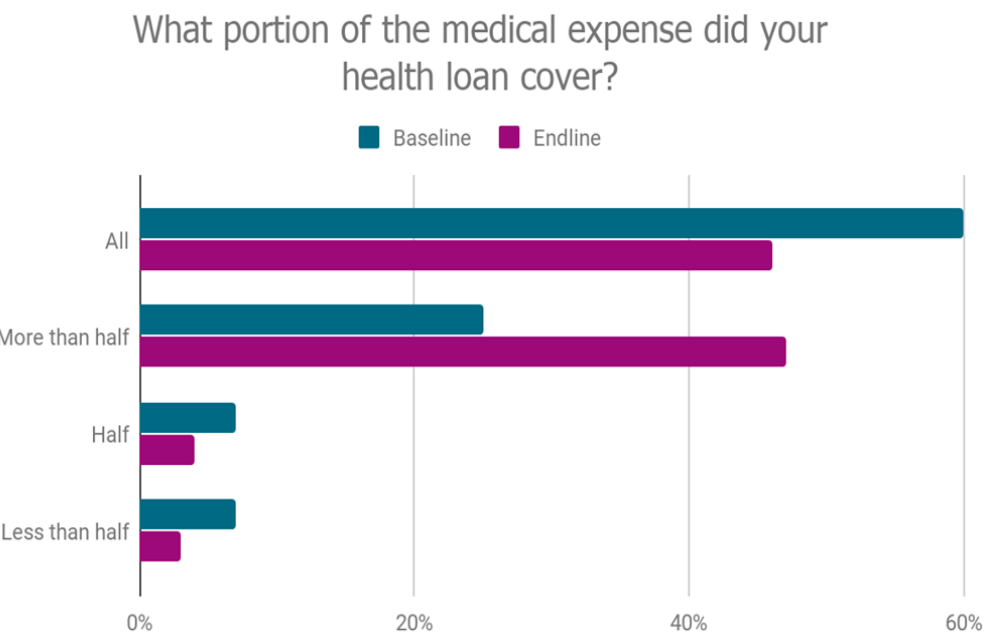
“If our group does not have enough savings for a health loan we just call the leader of a different group and if they can help we can go to them. Or, if another group doesn’t have enough in their health bag, that come to us.”

-Wives from End of Project Monitoring Assessment

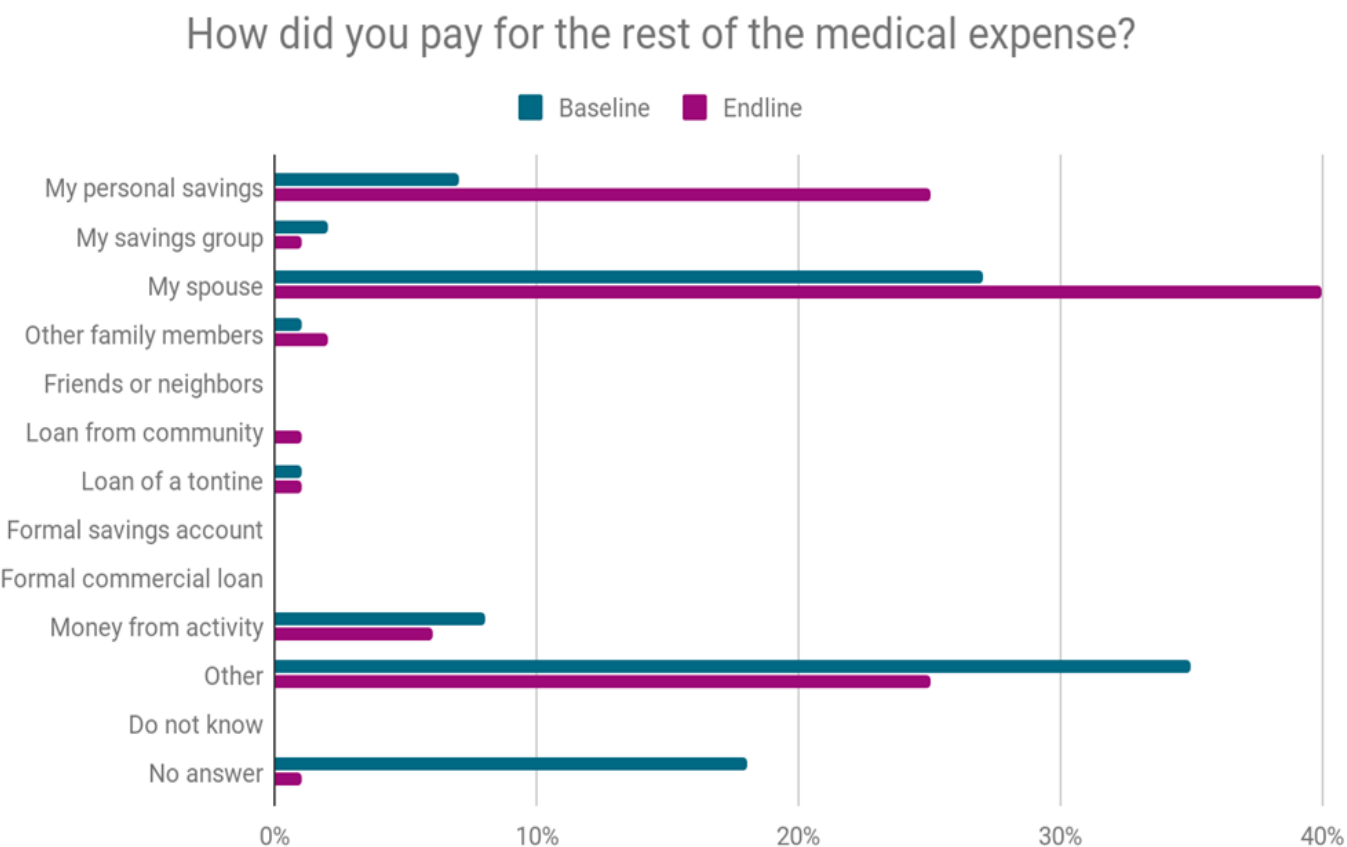


Coverage of Medical Costs with Health Loans

Although the reported health loan amount increased at endline, the SG members reported that the loans covered a smaller portion of the total medical expense compared to baseline.

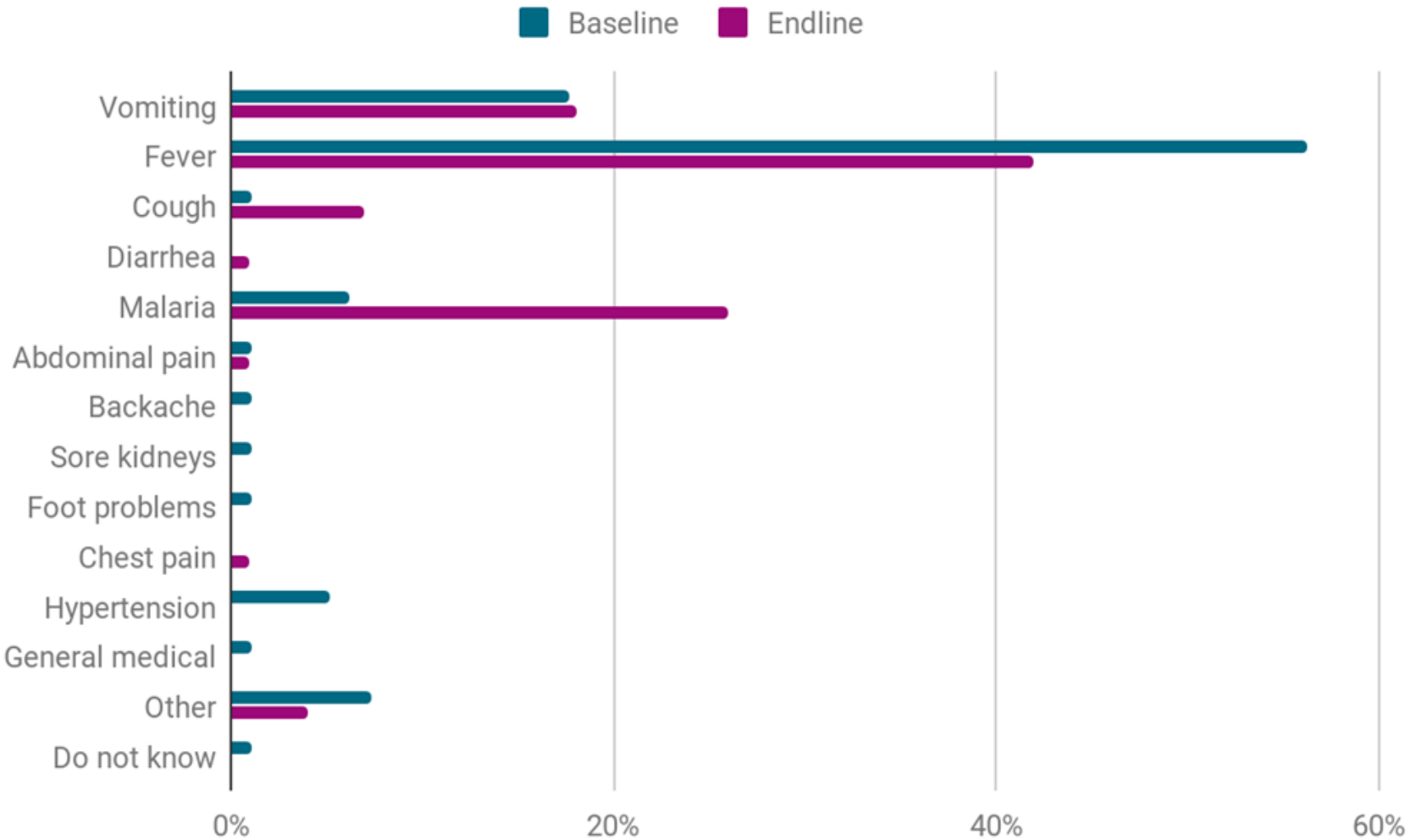


There was also a shift in how the rest of the expense was paid for. At endline, more women reported that they used personal savings and money from a spouse. Reported savings group use for health expenses remains low.



Use of Health Loans

- *Who* the health loan was used for remained the same from baseline to endline - first, a child under 5 years, then the respondent, followed by a child older than 6 years. There was however a shift in *what* the health loans were used for - a higher percentage using the loans for fever and malaria over baseline.
- It should be noted that the women were not given an option to respond that the loan was used for family planning methods.





Family Planning Education & Health Provider Linkages

Outcome 2: Improved knowledge of family planning methods and benefits

Outcome 3: Improved attitudes towards family planning

Family Planning Education



Sidonie

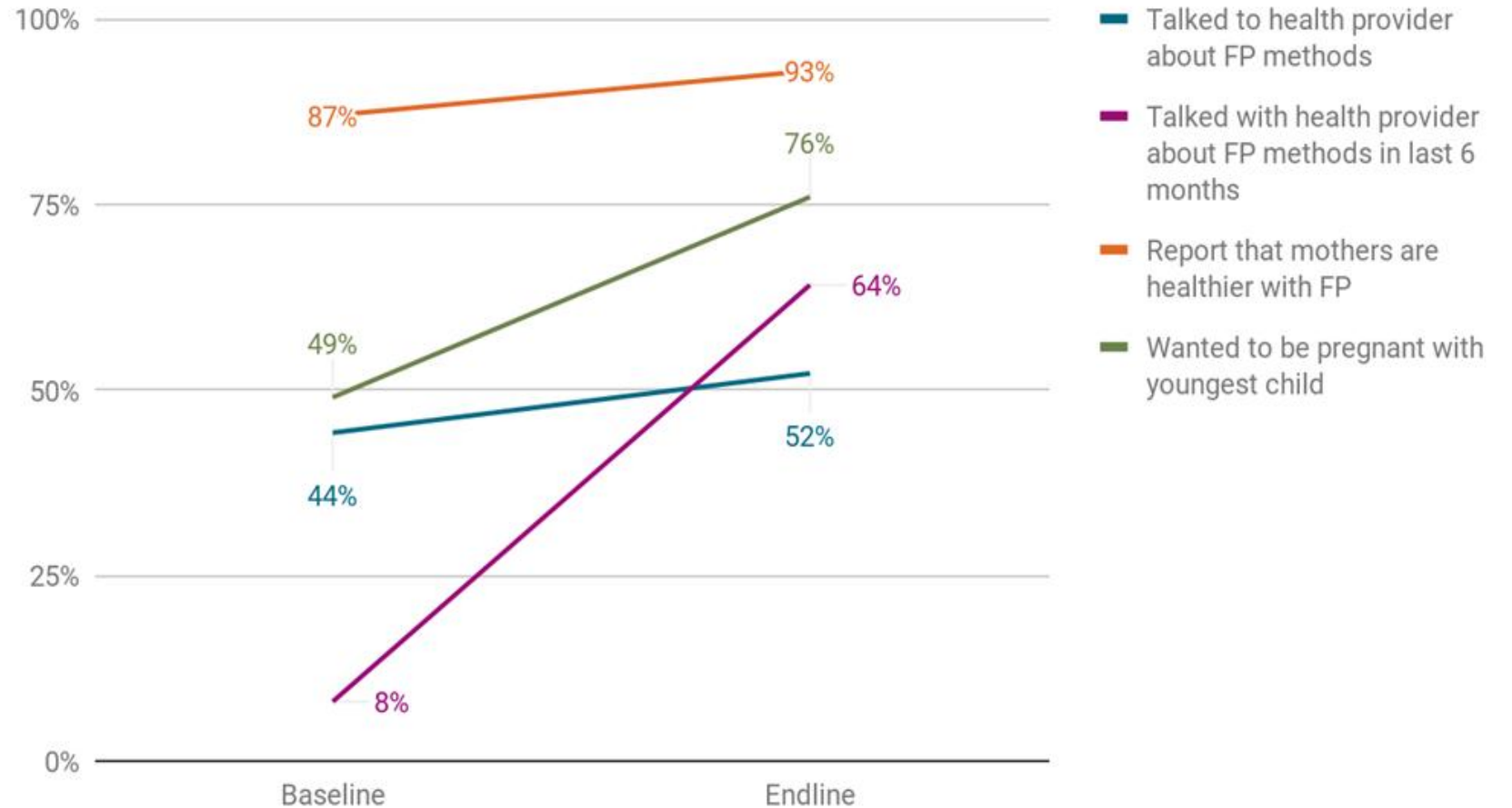
Sidonie is a Community Agent (CA). She knew that she had to be strategic when it came to sharing information about family planning to her savings groups and community. *“When delivering the family planning education it was a little difficult because some women were very opposed to the issue at first. We go slowly, talk wisely to calm them down and use friendly language.”* Sidonie learned that that persistence and patience was essential to getting buy-in on family planning from the community. *“I tried to talk about family planning to a group of men and women in one of the villages and people sent me away. But when I went back, I went to people individually in their homes. Then I finally called them together to talk. They accepted and even clapped for me at the end.”*

-End of Project Monitoring Assessment

Knowledge and Behavior about Family Planning

- Significant increase in talking to health professional about FP methods in last 6 months.
- Slight increase in reports that a mother's health is an important reason for FP.
- Interestingly, a dramatic increase in reporting that pregnancy with youngest child was desired.

"I convinced my sister and she started family planning. She had some side effects so I went with her to the health center and the health provider took us and explained things. She now feels well and continues family planning." - Wife, End of Project Monitoring Assessment



Assessing Quality of Experience with Health Providers

When a health loan is taken out, to verify a visit to a health provider as well as to provide feedback on experience, savings group members put stones in one of the three bags kept in the health savings box to “document” the type of experience they had when seeking health care::

- “Good” experience = 1 stone in green bag
- “Ok” experience = 1 stone in yellow bag
- “Bad” experience = 1 stone in red bag

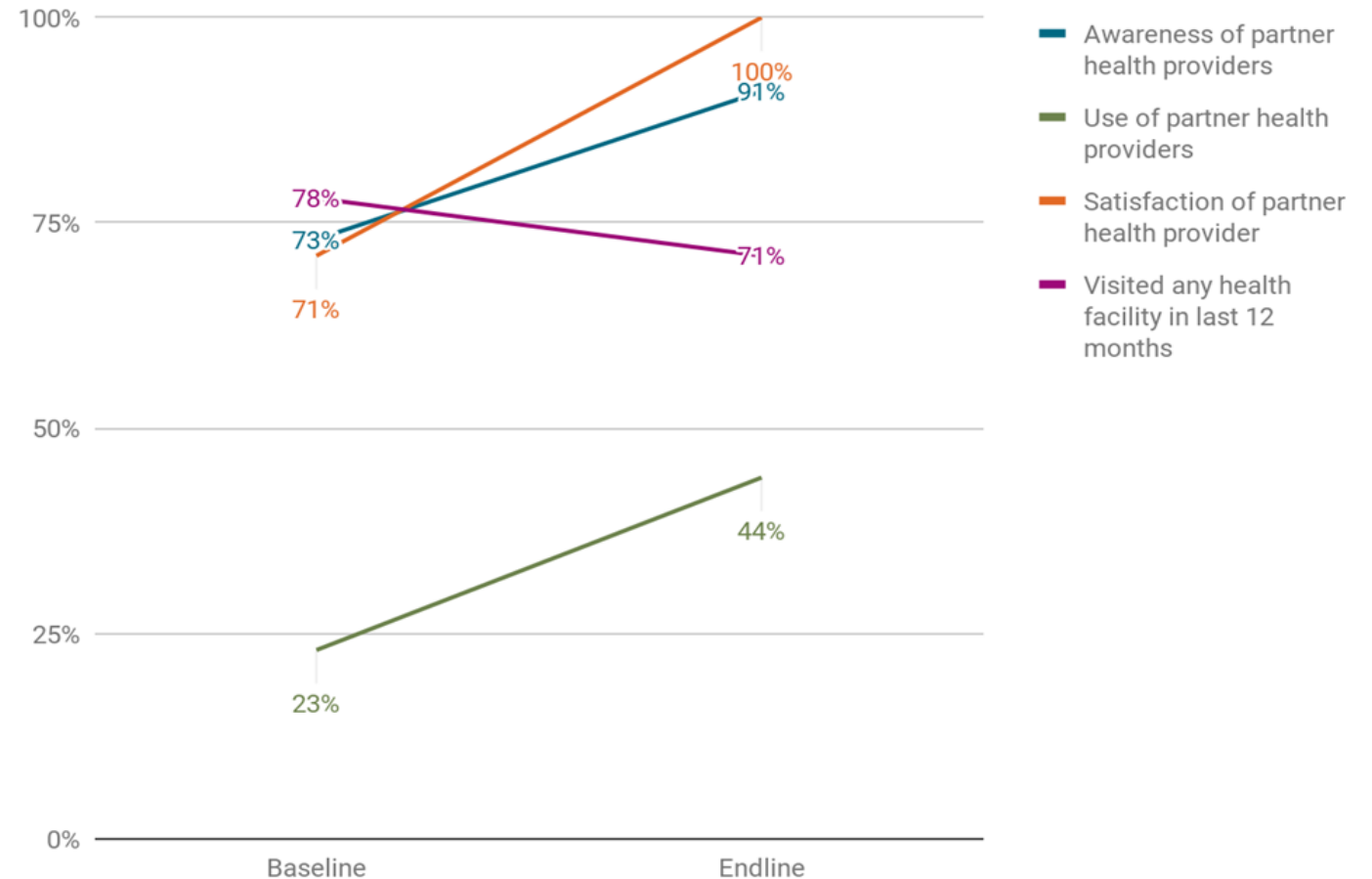
Every few months, staff from APHEDD and FADeC visit the savings groups to collect feedback using the bags, discuss with the groups their experiences and then circle back with the health providers to share the feedback with them in anticipation of improving savings group members’ experiences with future health services.



Assessing Awareness and Quality of Services of Health Care Providers

- Increases in awareness of partnered health providers, and increase use and satisfaction with those health providers.
- In contrast, a slight decrease in visiting any health facility in last 12 months to receive care for self or child.

“The women are confident they can come here and receive satisfactory health services. I give them a 50% discount for services, exams are free and medicines are a 50% discount. The partnership brings more patients to me, and money. About two times per month the women [savings group members] also clean all around the health clinic and even inside.” - Health Provider, End of Project Monitoring Assessment





Gender Dialogues

Outcome 4: Increased dialogue with spouses and health providers regarding family planning

Men and Women's Perspectives about the Gender Dialogues

Men

"If we have so many children without planning they will fall sick all the time. Family planning will save the family and the community—especially the women—because it is not easy to care for babies, the home and income activities."

"Family planning allows men and women to both do financial activities and you will progress. If there is a baby and pregnant woman, all the money will go to pay for medicines and care for them."

"I had heard about family planning before, but didn't know about it. Once the topic was brought up it was easier to talk about."

"Women may not be ready for sexual intercourse, so you may need to negotiate. We need to satisfy each other. If you are married and have children, you need to show respect to one another to bring the children up well."

"The family planning has done good things for us so far. Women were getting pregnant in close frequency. We are obliged now to go to family planning and this gives us peace in the home because we are not worried about pregnancy. And our children are safe—because of family planning we will lose fewer of them."

"I encourage family planning with my wife and encourage her. Because I know if I have too many children it will be difficult to support them. If there are too many, they will fall sick, get weak, and the woman can be weak if she is always pregnant and may even die during delivery."

"The traditional [family planning] method is using leaves from a tree. The woman would take these leaves but she still got pregnant when doing this. I would say it is better to go to the modern method. Even young ones, go for family planning, it is better than getting an abortion or dying."

Women

"Family planning is very helpful because it helps us plan the frequency of births. If you do that your children will progress in a good way."

"If women don't accept sexual contact with her husband it causes trouble in the home. My first arm implant did not work well and I told my husband that it was not working. He wanted an active sexual life but no child. So I went back and I changed and it works very well now. We have sex without fear now and no problem."

"I had 3 children and 3 months after the last birth I got pregnant again. The leader of my Savings Group told me I needed to talk to the health provider and eventually I got family planning after the baby. Now I'm having sex all the time but never get pregnant – I told my husband, this is the fruit of family planning! My husband heard from others in the community that I was using family planning, and I admitted it. My husband got angry and visited my parents. Finally I explained and he accepted. Now I have an implant in my arm and if I didn't tell you this you would not know!"

"If your body cannot recover before your next pregnancy you may even die. If you wait, recover and get stronger, the next pregnancy will be easier."

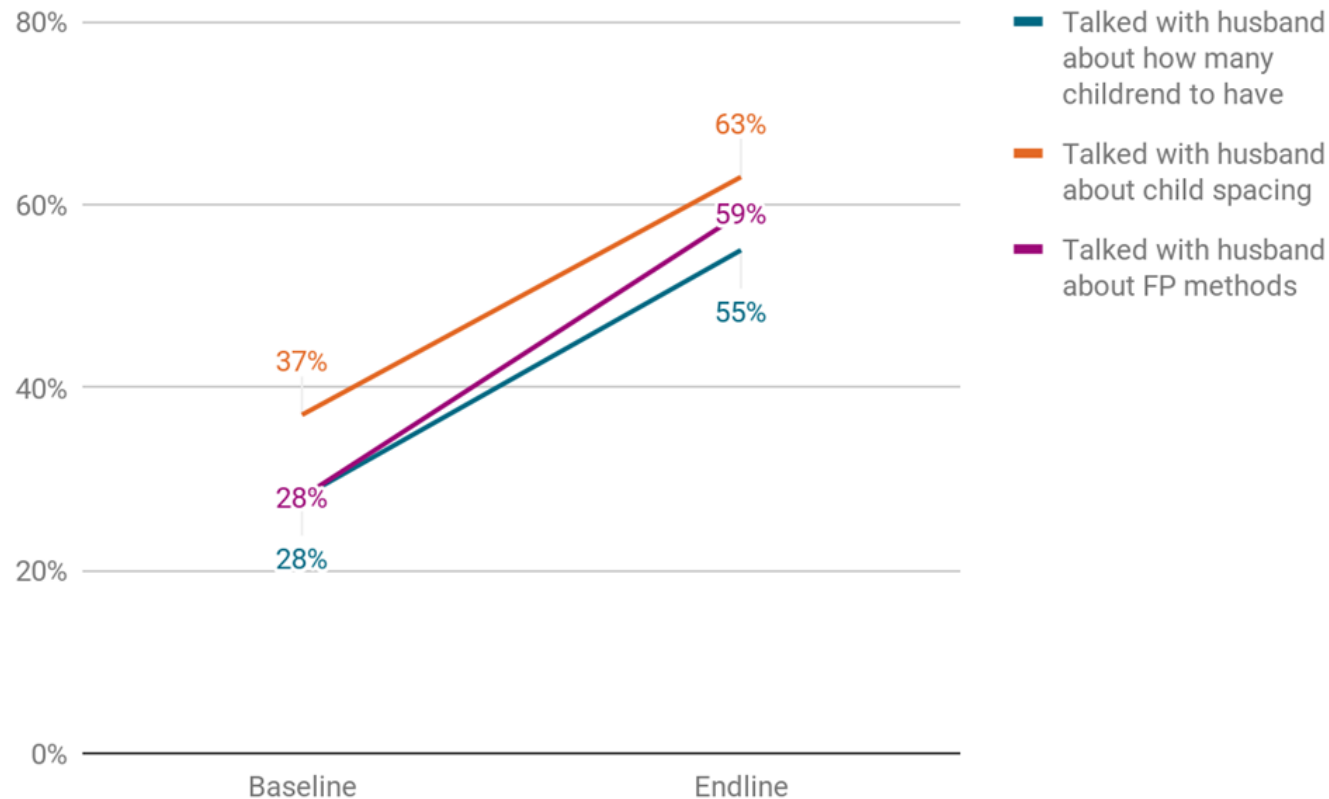
"A man will do his own work but sometimes he lacks and the woman will have to contribute. She will have to care for the kids. If the woman has her own money to contribute, she can support and make the husband happy."

"What was best is that our husbands were there participating themselves in the conversation."

Talking with Husbands about Family Planning

Dramatic increases in talking with husband about:

- How many children to have
- Child spacing
- Family planning methods



Things are changing in the world and getting harder and harder. Our parents had so many children. But things have changed a lot. If we want to progress we should know how to plan our life."

"Everyone knows that the resources needed for a family of two children and a family of six children are very different. And if you see the situation of so many children you will not desire it."

- Husbands from End of Project Monitoring Assessment

Gender Dialogues



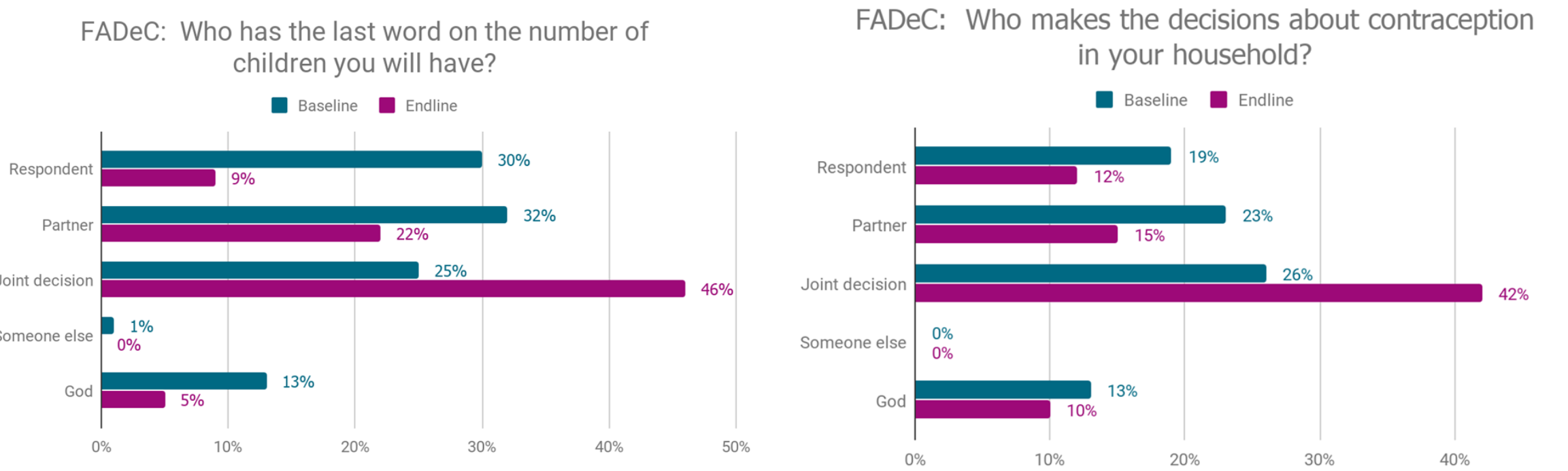
Philomène

After receiving the family planning education, Philomène, mother of four, discussed the different contraceptive options with her husband, including reasons that planning and spacing their children would be positive for the entire family. Philomène says, *“We were having so many babies, so he immediately accepted because it was needed.”* Philomène took out a 10,000 CFA health loan from her group’s health savings. Accompanied by her husband, she traveled to the district hospital and after an examination, received an IUD. The loan covered transport, testing, the consult and the IUD itself. Philomène says, *“now my sexual life is so easy, there is no problem at all...other people talk about family planning but in this case we meet as a group, we can ask questions, and talk about it as a group. We can feel comfortable and we can take our time to discuss it. What we used to hear about family planning, no one was explaining in detail, so we were not confident and we were afraid.”*

-End of Project Monitoring Assessment

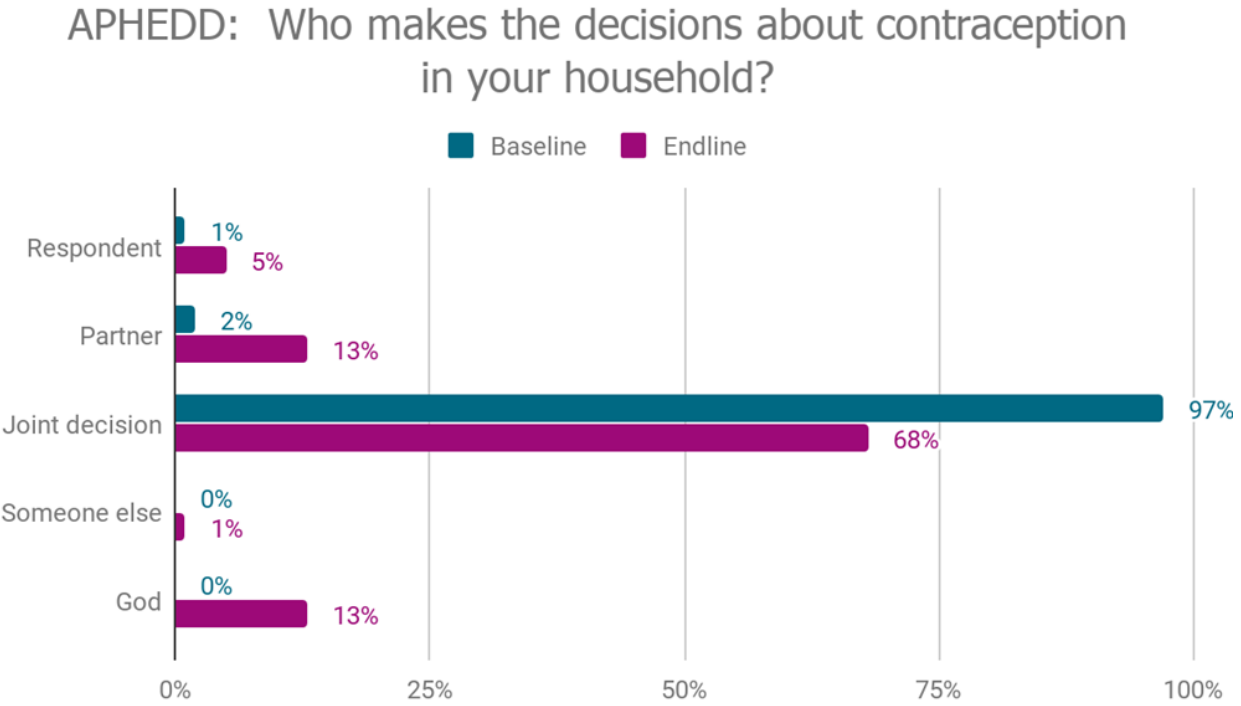
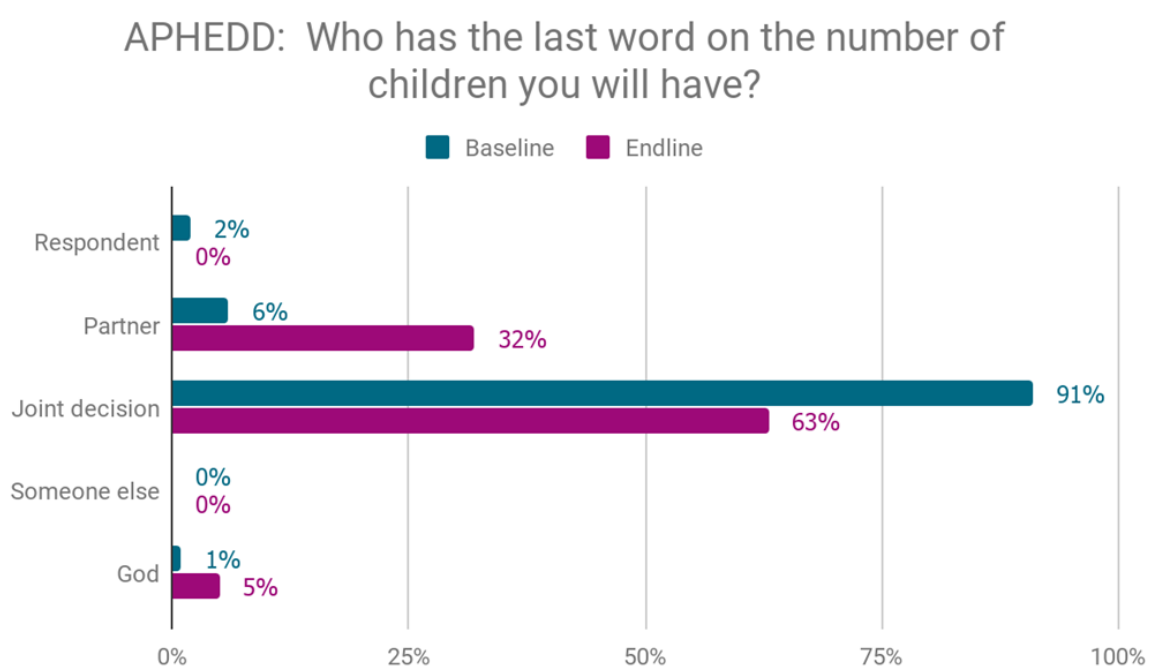
Who Makes Family Planning Decisions among FADeC Clients?

Dramatic shift from baseline to endline with significantly more FADeC clients reporting family planning is a joint decision. The decision pattern remained consistent between the two questions below:



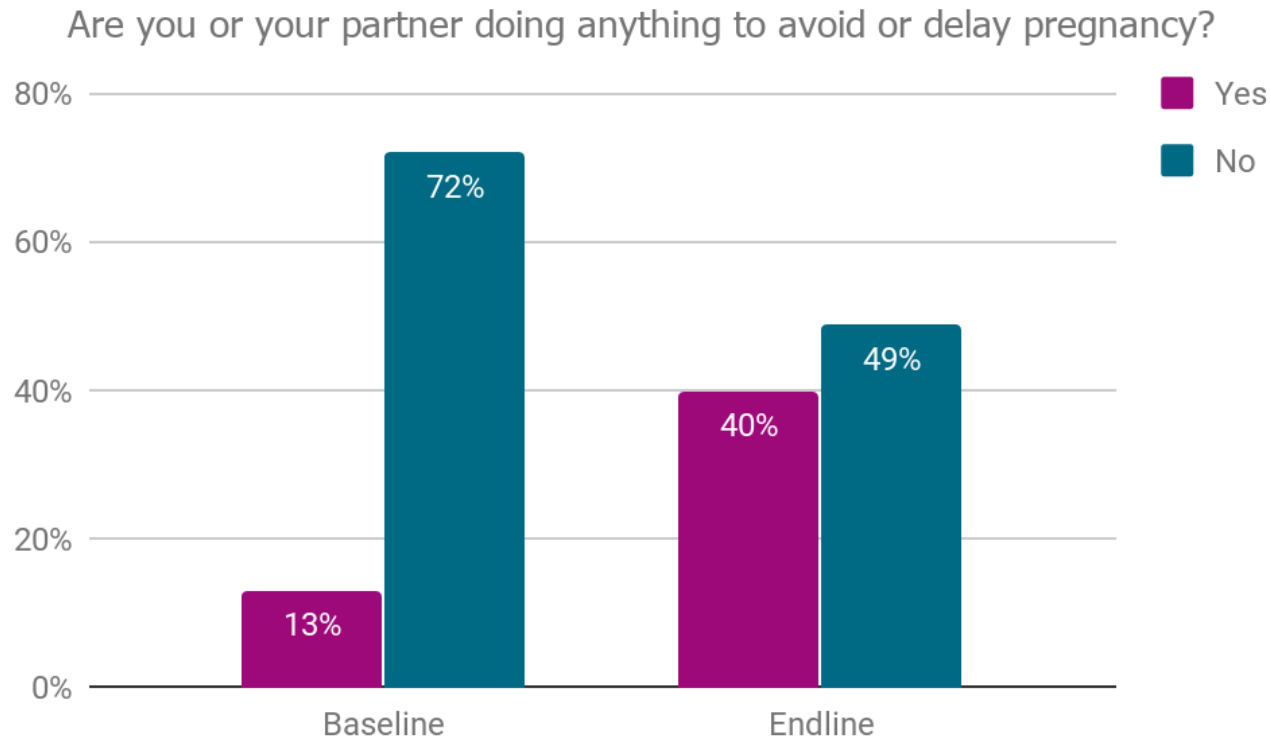
Who Makes Family Planning Decisions among APHEDD Clients?

Dramatic shift from baseline to endline with significantly *less* APHEDD clients reporting that family planning is a joint decision. The main difference came from an increase in reports that it is the partner that makes the decision. Follow-up with APHEDD staff indicate that the SG members reported stronger role of spousal decision-making due to encouragement by the community agents to engage husbands in the decision. The decision pattern remains consistent between the two questions below:



Contraception Use

In 2013 the use of contraceptives among women in Benin aged 15-49 was 9%. The issue has been the focus of a national campaign to increase use of contraceptives and by 2018 it had risen to 14%.¹ The efforts of Grameen's program, including the involvement of men and access to financing among the target population, may have helped to influence the dramatic increase in contraceptive utilization from 13% at baseline in 2017 to 40% at endline in 2018.



"I talked to the wife of my senior brother and I explained to her the program and that she can go to the health center to get family planning, because she already has so many children. I then invited my brother, with my husband, and we said that there is a program to explain how to decrease the birth of children. My brother finally accepted and his wife is now engaged in family planning."

- Christiane from End of Project Monitoring Assessment

¹<https://www.familyplanning2020.org/benin>

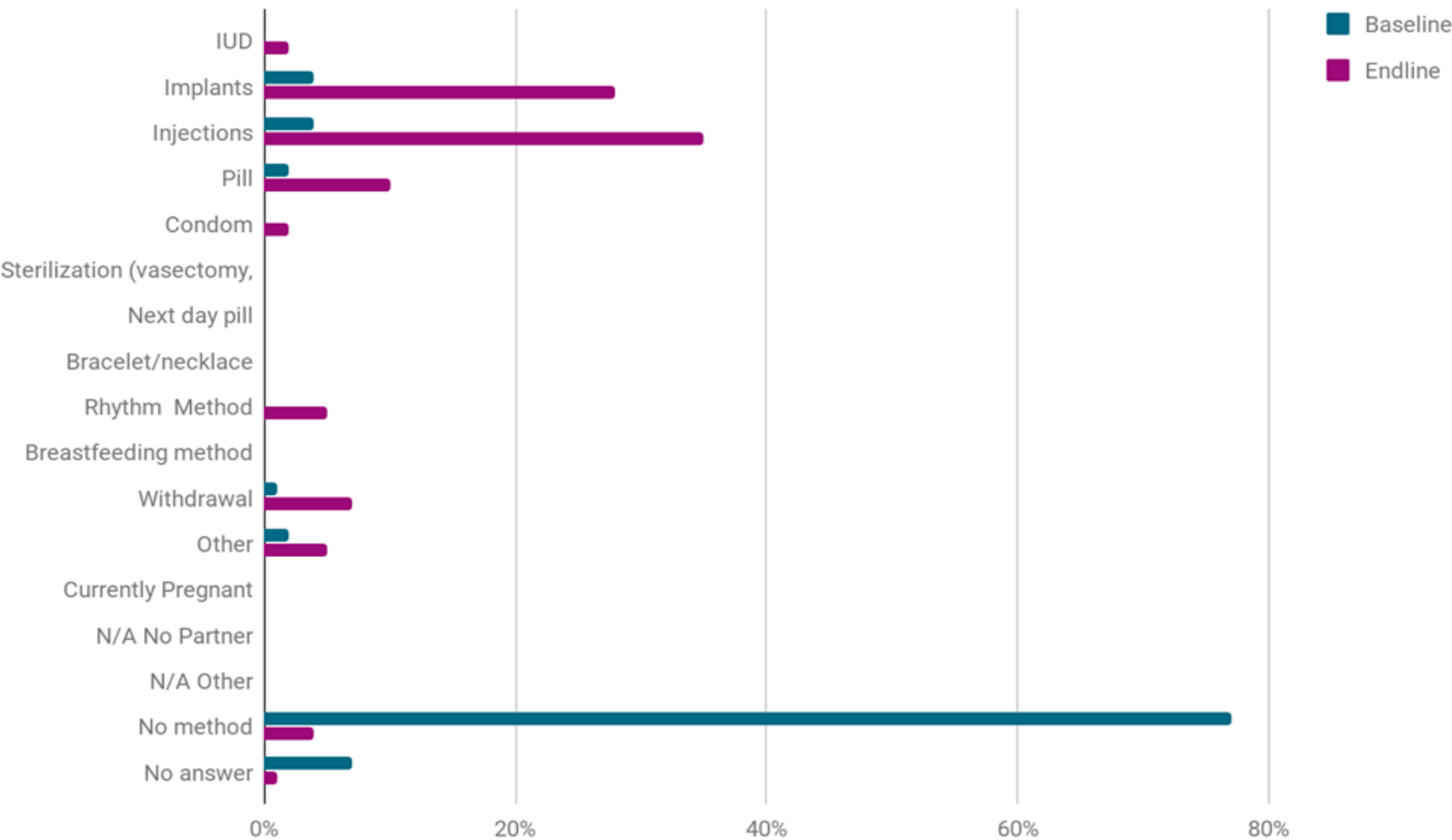
Current Contraceptive Method Use

At baseline, all 204 survey respondents were asked what family planning method they currently use. Most reported “no method” followed by “no answer,” “implants” and injections.”

At endline, the question was changed so that only those who indicated that they were currently using a method were asked which type. This resulted in 81 answers from the survey respondents. Again the most common methods reported were “injections,” followed by “implants,” and the pill.

“Women prefer arm implants, injection and IUDs.” - Health Provider, End of Project Monitoring Assessment

It should be noted that over half of the women report that IUDs are most readily available at the local health center which is in contrast to how often they are reportedly used compared to other methods.



Contraception Use



Brigitte

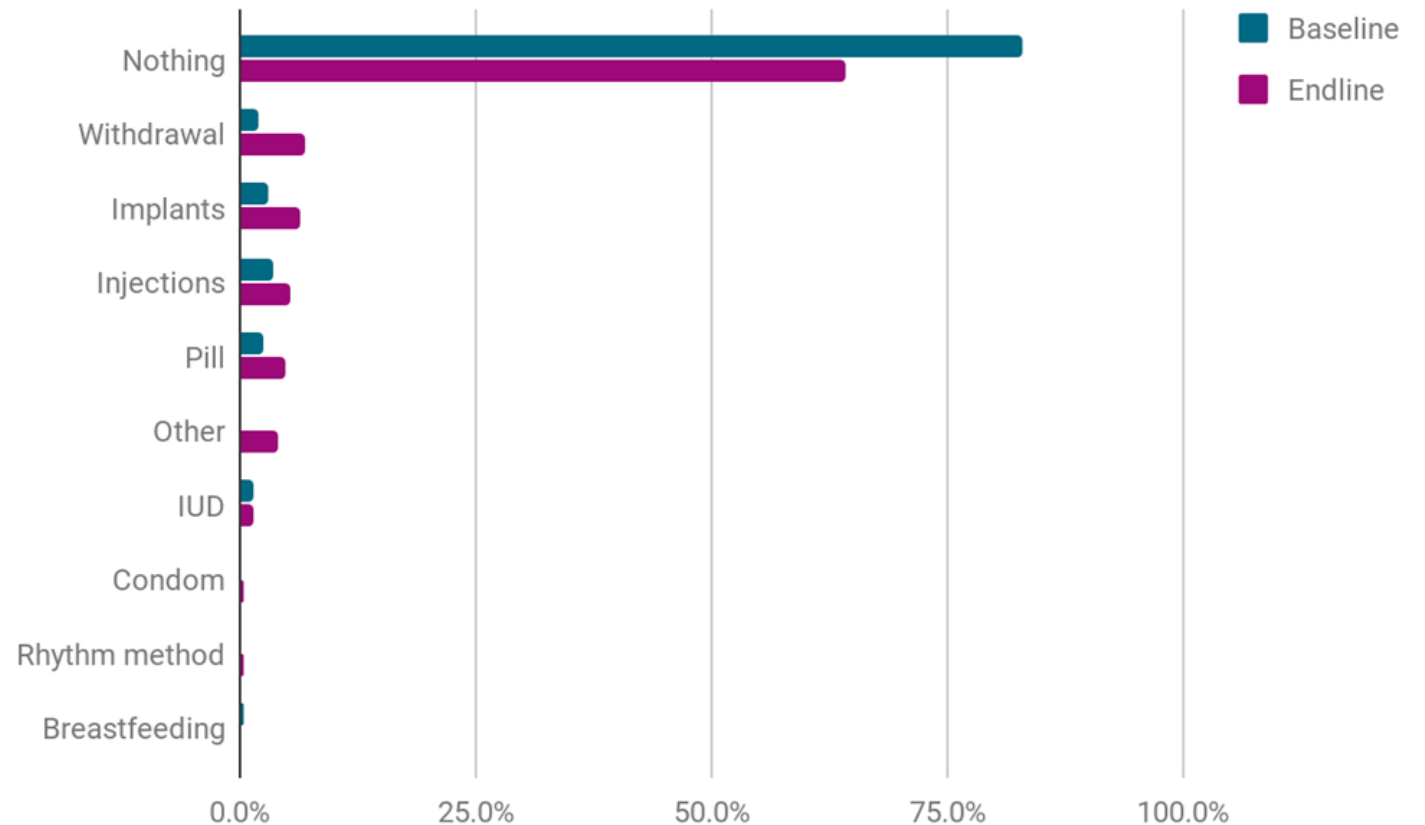
Brigitte has 7 month old twin girls. There was tension in her home after the birth of the twins because of the great amount of work caring for the babies and other children, but also because she did not want to become pregnant again right away – and therefore refused sex with her husband. Brigitte's husband agreed to come with her to visit the local health provider. She took out a 5,000 CFA health loan so that she could pay for long term contraception. Fortunately the health provider, along with Brigitte, was able to convince her husband to accept family planning. Brigitte can now care for her twins without fearing a surprise pregnancy.

-End of Project Monitoring Assessment

Past Contraception Method Use

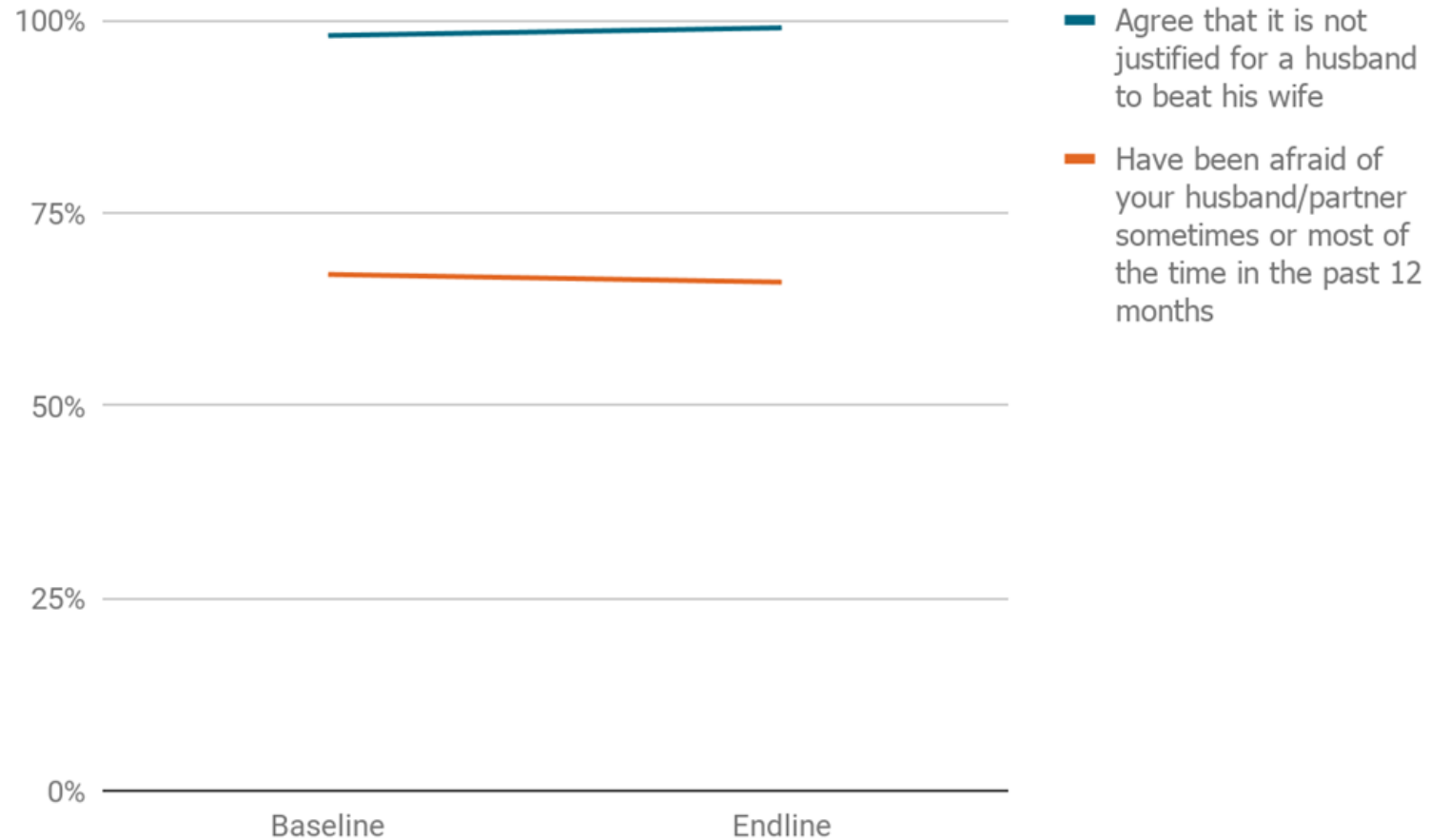
- Decrease in reports that “nothing” is used for contraception. All methods used at baseline increased by endline with the highest increase in the “withdrawal” method (100% FADeC clients) followed by “implants.”
- Side effects were cited as the most common reason for never using a contraceptive method at baseline followed by “I don’t understand the methods.”
- At endline, side effects were again cited as the most common reason for not using a contraceptive method, but unlike at baseline, the second most common reason cited was “it is God who decides.”

“Possible side effects are the biggest concern. Counseling helps them choose. We explain it thoroughly. Some come with their husbands and even some husbands even help pick.” -
Health Provider, End of Project Monitoring Assessment



Gender-based Violence

- No change in reports that husbands are not justified in beating their wives.
- No change in how often felt fearful of husband.





Healthy Savings for Better Reproductive Health in Bénin
Conclusion

Summary of Results for Health Savings

Desired Outcome 1: Increase health savings to support treatment-seeking behaviors

Results:

- There was no change in women using health loans for family planning or for related transportation costs. However, while group-based health savings can reduce the need to turn to family and friends, it does not altogether keep a woman's health needs private as the group still has to agree on providing a health loan to the women, which requires her sharing the need for which the loan is being requested.
- Confidence in covering health costs also remained unchanged but was very high at baseline at 98%. Average savings amounts increased as did the average loan amount, yet actual use of a health loan remained virtually unchanged over baseline. In addition, the distribution of health funds continue to be used for household goods. This warrants a discussion if there is an emotional need being met by the health savings as opposed to a financial one. The findings in the end of project monitoring assessment also suggest that the health savings offer a sense of security:

"We never allow for the health savings bag to be empty."

"I feel safe when I save for health. When you have a health problem the health savings is there to help you."

"I like the health loan because it is not for business. It is for us and our children when we fall sick. It is a safety bag."

- Confidence in coming up with emergency funds increased slightly, and more reported that coming up with these funds would come from SG funds and personal savings rather than money earned while working or family and friends at baseline (this was primarily driven by FADeC clients). Loans from SG increased slightly over baseline.
- Although the reported health loan amount increased at endline, SG members that used the loans reported that they covered a smaller portion of the total medical expense at endline. There was also a shift in how the gap was covered. More women reported that they used personal savings and money from a spouse at endline. Reported loans for medical expenses from the general savings group funds (as opposed to health savings) remained unchanged.
- *Who* the health loan was used for remained the same from baseline to endline - first, a child under 5 years, then the respondent, followed by a child older than 6 years. There was however a shift in *what* the health loans were used for - a higher percentage using the loans for fever and malaria at endline.

Summary of Results for Family Planning Education & Health Provider Linkages

Desired Outcome 2: Improved knowledge of family planning methods and benefits

Desired Outcome 3: Improved attitudes towards family planning

Results:

- Increases in awareness of partnered health providers, and increase in use and satisfaction with those health providers.
- In contrast, a slight decrease in visiting *any* health facility in last 12 months to receive care for self or child.
- Significant increase in talking to health professional about FP methods in last 6 months.

“I didn’t know there were various contraceptive methods and that you can work with the health provider to discuss the right one for you before engaging in it.” - Wife, End of Project Monitoring Assessment

- Slight increase in reports that a mother’s health is an important reason for FP.
- Interestingly, a dramatic increase in reporting that pregnancy with youngest child was wanted.

“This has brought peace in the family. Before, I was less clean and had so many children all the time. I am like a young lady now and the children are well and my husband and I have a good sexual life. It has brought joy into the home. I also brought this information to my daughter and her husband and how they are happy. I wanted her involved. They went to the health provider and she helped them and they are happy. There is less violence in the house.”
- Wife, End of Project Monitoring Assessment

Summary of Results for Gender Dialogues

Desired Outcome 4: Increased dialogue with spouses and health providers regarding family planning

Results:

Oxfam recently published findings using a similar approach of combining savings groups and reproductive health to address sociocultural barriers in Mali. Oxfam reported [findings](#) of increase knowledge and use of contraceptives though working with women's savings groups but did not include a gender dialogue component and specifically noted the imperative of working with men and women in order to increase the rate of family planning methods.

- Dramatic increases in talking with husband about:
 - How many children to have
 - Child spacing
 - Family planning methods

“It is not easy to introduce the topic alone, but with the gender dialogue, the topic is shared with all. When you want to come back and talk about family planning it is very easy because it has already been introduced.” -Wife, End of Project Monitoring Assessment

“That very night after the gender dialogue, family planning was the topic of our discussion.” - Wife, End of Project Monitoring Assessment

- Significant increase in contraceptive use over baseline which is consistent with a decrease in reporting that a contraceptive methods have not been used in the past.

“When I learned about family planning, it changed my life. I used to have children very frequently and I had health problems. I have now become close friends with my husband. We are happy now, and we can have safe sex. Now we can both more easily make money and share expenses. My husband says I am like a new wife to him – I am relaxed, and we are happy.” - Wife, End of Project Monitoring Assessment

- Dramatic shift from baseline to endline with significantly more FADeC clients reporting that deciding on the number of children and whether to use contraception or not is a joint decision. Dramatic shift from baseline to endline with significantly *less* FADeC clients reporting that deciding on the number of children and whether to use contraception or not is a joint decision. The main difference came from an increase in reports that it is the partner that makes the decision.
- While the project didn't directly try to address domestic violence, the survey data suggests there was no change in beliefs that husbands are not justified in beating their wives nor a change in how often women felt fearful of husband.

Lessons Learned

Group solidarity is key: Women said they heard about FP from radio messaging, health providers, among others but there was little in-depth explanation and they did not fully trust the source. Hearing from the Community Agent and discussing it over weeks and as a group was found to be very important.

Older women played an important role. Older women often spoke up and said they wished they had had this program and access to FP products when they were bearing children. They then said they did the next best thing and encouraged their children to engage in FP.

Education before Gender Dialogues is best. Staff from both organizations felt it was crucial to first convince the women of FP and get them “on-board” before approaching the men. In this case, at least before the education, many of the women were skeptical. But they were for the most part fairly easy to convince during the course of the education. The men were much harder. The CAs and Facilitator’s needed the women’s help to convince the men. Also, in polygamous societies (as many of these are), the local FSP partners felt that women sometimes compete in the number of children they bear for their husband. These women needed to be on the same page and come to some kind of truce before involving the men.



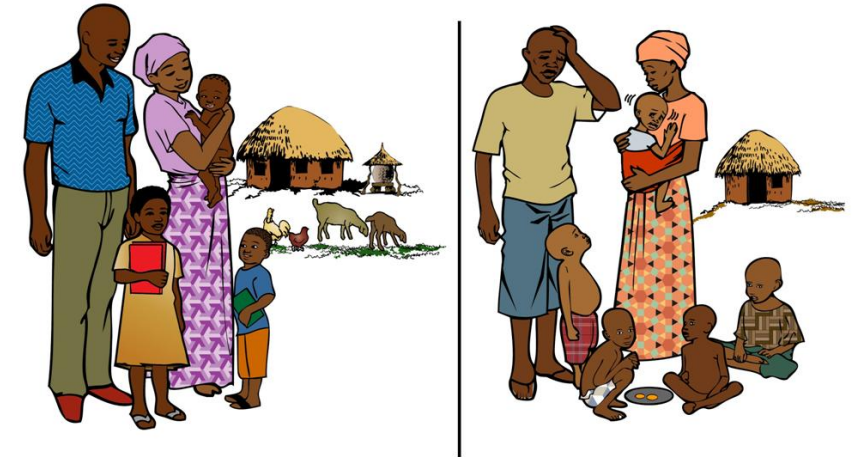
Lessons Learned

Women were most successful when they “strategically” broached the topic of FP with their husbands. Many women said they cooked their husband their favorite meal, had the house clean and/or brought up the topic in bed (many cited all three). They primed him to be in a good mood before they broached FP with him.

Important to lay the groundwork, pre-program: Before the FP education was delivered, facilitators shared and discussed the program with village chiefs and leaders to get their blessing and buy-in and later, they did the same for the Gender Dialogues. In many cases the chiefs then not only attended the gender dialogues but encouraged the men to join and also gave the message to the “town crier” on the day of the gender dialogue.

Be strategic in time of day and year to encourage male participation in the gender dialogues. Afternoons and non-harvest times of the year were best for male participation (in the Beninese context).

Gender dialogues took the pressure off the women in terms of broaching the subject of FP with their husbands. Although many women talked to their husbands after the education and before the gender dialogues, others shared some facts during the education but then waited until the gender dialogues to really bring up and discuss the topic with their husbands. Many said that it was easy and natural to bring up the topic at home after the gender dialogues, which they appreciated.



Lessons Learned

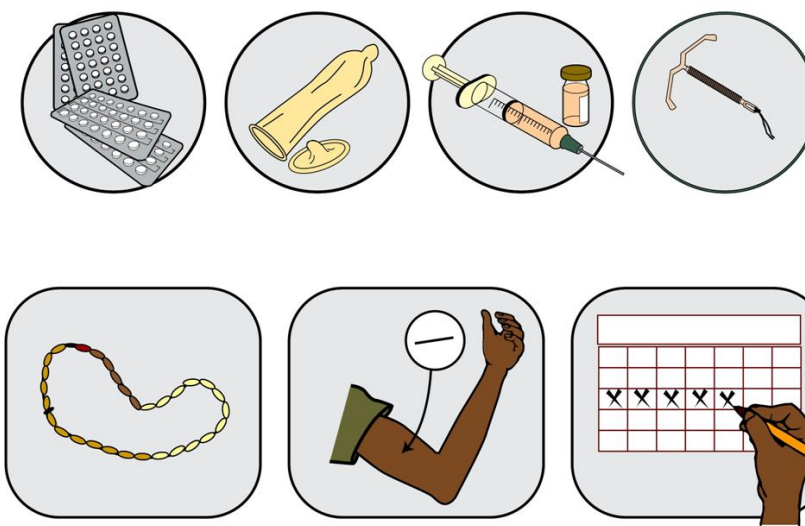
Having a male (FSP partner) facilitator was very helpful. The male facilitator was respected and listened to by the men. The men trusted and asked him questions that they likely otherwise would not have asked a female facilitator. This greatly helped with buy-in.

“Choosing what’s best for the family” versus “limiting number of children” was an effective way to frame the FP messages. The SG members appreciated not being told to have fewer children or to not reproduce. The messages gave them the tools and information they needed to have a conversation about what is best for their family in terms of how many children to have and how frequently, taking into account finances, resources, mother and child health and future opportunities.

Gender Dialogues were best delivered jointly by one male facilitator and one female facilitator. It was helpful to have one facilitator representative from each gender conduct/support the gender dialogues.

Positive deviants are key. When women tried FP, most seemed to have a good experience – sharing these experiences or “good rumors” versus the negative ones was very encouraging to their peers. Being in a solidarity group encouraged this sharing and eventual uptake.

Increased peace in the home. Women and men commented that due to all of the above – more income, lack of babies + pregnancy, and more intimacy between partners led to “more peace in the home”. There was also some mention of less violence in the home because there was not as much stress and because both were more open to sexual relations.



Lessons Learned: Top Reasons for Engaging in FP

Women

- Economic contributions to the HH: Women reported that they really like having their own income generating activities, which provides some autonomy, independence and the ability to contribute to the HH economically.
- Avoid being pregnant while caring for a baby: Many talked about the burden of having a baby in the belly and on the back and that ideally they wouldn't get pregnant again until their youngest child was more independent and not "on" or by them all day. This was tiresome and impeded their income generating activities, keeping the house clean and so forth.
- Improved sex lives: They said they no longer feared getting pregnant while having sex, which made it more enjoyable and they were more willing to have it when their husband wanted it, making their husbands happy.

Men

- Economic contributions to the HH: When women are not pregnant or caring for young children they have more time for their income generating activities, bringing in more money for the household.
- Improved sex lives: Men said that women were more relaxed and wanted to have sex more frequently and/or they were not turned away when they wanted to have sex with their wives when using FP.
- Safer, healthier children and women: Men seemed convinced per what they have seen or experienced previously –that spaced children tended to be healthier and better cared for and incurred fewer health expenses-- and that their wives were also stronger and more able to contribute to the HH.

Integrated Microfinance and Health: Supply meets Demand

Integrating microfinance and health services provision assists in ensuring that supply of health services is met with demand from communities for their services.

Supply:

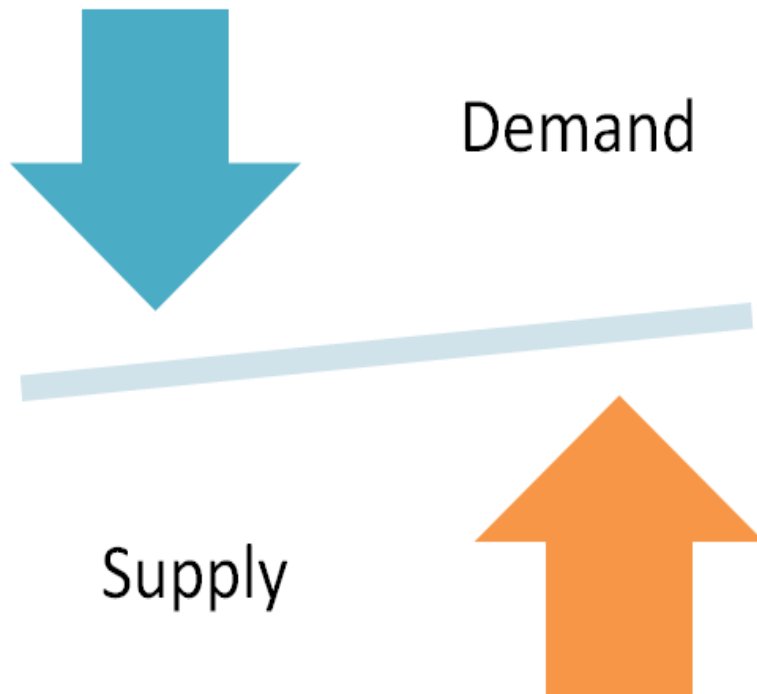
- Linkages from Financial Service Providers to Health Providers provides visibility and confidence in health services among communities.
- Financial Service Providers advocate for quality services on behalf of their clients.
- Health providers have an advocate in FSPs to ensure communities adhere to treatments and health services, such as for antenatal and postnatal care, immunizations, etc.

Demand:

- Clients participate in awareness-raising campaigns, ensuring they are educated on appropriate health and treatment-seeking behaviors.
- Clients have access to health savings and loans to assist in covering out-of-pocket expenses.

It's a win-win-win proposition:

- Clients experience better health and reduce financial stress due to tools designed to assist them in covering health expenses and confidence in their ability to take care of their families' health.
- Financial service providers have healthier clients, and therefore a healthier financial portfolio.
- Health providers effectively cover their communities with necessary medical services, meaning public and private health goals.



Empowering Ecosystems for Rural Women and Their Households

Grameen Foundation's programs and partnerships aim to strengthen five main elements of an empowering ecosystem for women described to the right. Interventions are designed to ensure that most programs address these elements and they are also used to measure beneficiary outcomes to determine the success of the interventions.

For the *Healthy Savings for Reproductive Health in Bénin* project, the five main elements of the ecosystem can be used to highlight the interventions that were implemented:

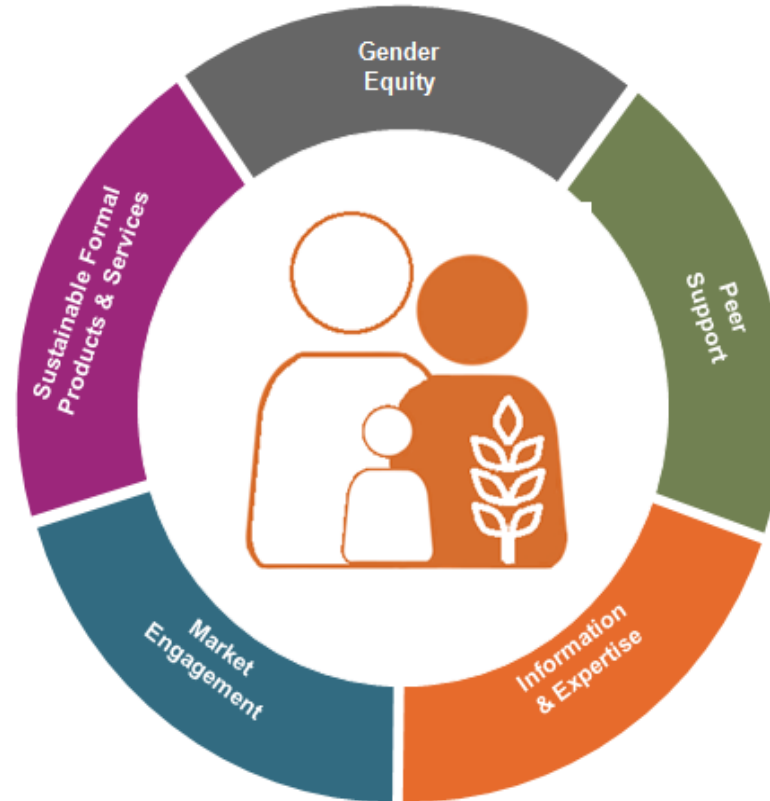
Gender Equity: The involvement of men in the sixth PLC meeting as well as the gender dialogues directly address gender equity by acknowledging the role of men in decision-making regarding family planning.

Peer Support: Women's savings group community agents served to support group members in accessing health financing and services.

Information and Expertise: Health education provided women with information on family planning and modern contraceptive methods.

Market Engagement: Linkages between financial and health service providers and availability of health savings and loans encouraged women to actively use local health services.

Sustainable Formal Products & Services: The formal collaboration of local health and FADeC/APHEDD staff provides ongoing identification of community health needs and areas of needed collaboration.



GENDER EQUITY

Interventions and information that bring about transformation of gender norms, rebalancing power towards women

PEER SUPPORT

Empowering a community to work together, providing encouragement and support to each other through peer groups

INFORMATION & EXPERTISE

Building the awareness and skills of the rural poor by providing relevant information in ways they can access and understand

MARKET ENGAGEMENT

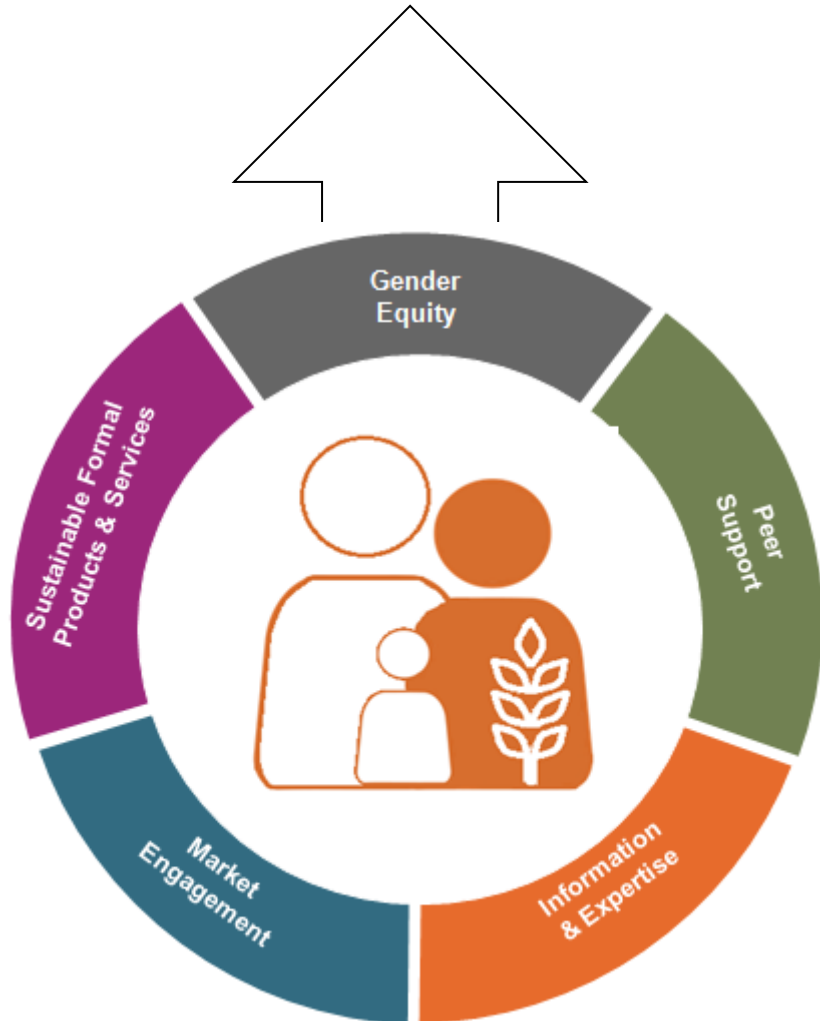
Providing access to the marketplace and enabling more money from the value chain to flow through to the rural poor

SUSTAINABLE FORMAL PRODUCTS & SERVICES

Carefully designed products and services delivered in a way that poor people can benefit from and that can be sustainable

Measuring Our Success

Improve the health of rural women and their children through increased access to and use of family planning methods.



Using the ecosystem as a framework for evaluating the success of the *Healthy Savings for Better Reproductive Health* program in improving the health of women and children in Bénin through increased access to and use of family planning methods, we find the following short-term outcomes:

Gender Equity

- Increased perception among FADeC clients that FP is a joint decision.
- Decreased perception among APHEDD clients that FP is a joint decision. This is an area to explore to determine if the interpretation of husband's role in FP was influenced.
- Increased family planning dialogue with spouse.

Peer Support

- Increased awareness, use, satisfaction, and dialogue about family planning with partnered health providers.

Information and Expertise

- Increase in understanding of family planning methods.
- Increased use of family planning methods.

Market Engagement

- No change in access and use of health savings and loans, but increased average weekly savings.

Sustainable Formal Products and Services

- The provision of health services through an existing sustainable savings group platform generates marginal costs, allowing for sustainability of the integrated financial services-health strategy for the health providers.



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