Repositioning family planning through natural methods: Experiences from Benin and Burkina Faso

Introduction:

Poor reproductive health in Sub-Saharan Africa has contributed to some of the world's highest infant and maternal mortality rates, as well as a loss of human capital contributing to stagnant economic growth and increased poverty. Sub-Saharan Africa's population has doubled in just 25 years--and is projected to double again in less than three decades, even when taking into account declining birthrates and rising deaths from AIDS[1]. For more than 20 years, population growth of almost three percent a year has outpaced economic gains and increases in food production, leaving Africans, on average, 22 percent poorer than in 1975[2]. The unmet need for family planning is huge. The 2005 Population Reference Bureau estimates that only 14% of SSA women in union said they had used a modern contraceptive method at some time in their life.[3]

The countries of Burkina Faso and Benin represent a microcosm of Sub-Saharan Africa weak health indicators. Their population is characterized by extreme youth (49% less than 15 years of age; 3.6% over 65 years of age in Benin and a little less in Burkina Faso), and by high fertility and a rapid growth rate (2.7% per year). The estimated unmet need for family planning is 28.8% in Burkina Faso and in Benin the total fertility rate (TFR) was 7 children per woman in 2005 compared to an average of 5 in Africa[4]. Although knowledge of modern family planning methods is high and these methods are available in most of these countries, many Burkinabé and Beninois women prefer to use natural or traditional methods. Among the approximately 14% of women of reproductive age who report using some method of family planning, 4.2% report using a traditional method.[5] Increasing access to methods that can be provided both in clinics and at the community level and are culturally appropriate has considerable potential for increasing family planning use and improving optimal birth spacing in these countries.

The Standard Days Method (SDM):

The Standard Days Method (SDM) is a new FAB method developed at the Georgetown University Institute for Reproductive Health. It is effective and is easier to offer, learn, and use than other FAB methods. The SDM is based on the physiology of the menstrual cycle and the functional life span of the sperm and the ovum. It is appropriate for women whose menstrual cycles usually are between 26 and 32 days long (approximately 78% of cycles are within this range)[6]. Couples using the SDM are advised that the woman should be considered fertile on days 8 through 19 of her cycle (all users in all cycles), with day one being the first day of menstruation. Couples who wish to avoid pregnancy do not have unprotected intercourse on those days. Users do not need not monitor temperature, cervical secretions, or any other symptoms of fertility.

the SDM is used with a visual aid called Cycle-Beads, a color-coded string of beads that help a woman keep track of her cycle days, know which days she can get pregnant (days eight through 19), and monitor her cycle lengths to be sure they continue to be between 26 and 32 days long. To use Cycle-Beads, she moves a rubber ring over one bead every day to track where she is in her menstrual cycle. The colors of the beads indicate whether she is on a fertile or infertile day. Women are counseled to avoid intercourse when the rubber ring is on a white bead, representing a fertile day.

An efficacy study conducted in Bolivia, Peru, and the Philippines show that the method is highly effective, with a typical use failure rate that is comparable to that of condoms and other user-directed methods of family planning.[7]

The SDM in Burkina Faso and Benin

The SDM was first introduced in Benin and Burkina Faso through a pilot study. The major objectives of the study were to test and document incorporation of the SDM into health programs in these countries; measure correct use and continuation of the SDM; assess how women/couples use the SDM; and estimate user acceptance and satisfaction. The study was implemented over a 23-month period in selected sites in both countries. The results of the study showed that the SDM is culturally appealing to couples in both countries. The interest in the SDM lies in its scientific basis and ease of use. The positive results of this study motivated the MOH to scale up the program nationally.

In scaling up the SDM, IRH trained trainers and providers in all regions according to the existing health structure in both countries. An important facet of the SDM introduction efforts was forming strategic partnerships with organizations providing expertise, geographic coverage, and access to specific population groups and by transferring FAB method capacity to them. IRH's main partner was the MOH, in that all trainings of trainers and provider trainings were coordinated with the national, regional and district levels of the MOH. IRH also worked with the MOH to pursue SDM integration into established health systems, such as the commodities procurement and distribution system, supervision system and MIS. IRH also coordinated trainings with other partners offering services in the districts where training was conducted, including faith based organizations, women groups, and private sector clinics. IRH worked with those partners to ensure that their own organizational supervisors, in addition to the public sector providers, were trained in the SDM and understood what supervision would entail.

After training providers and community health workers on the SDM and promoting the method through local media. Ministries of health, NGOs, and faith-based organizations integrated the SDM into their FP programs. In order to assess integration, country monitors collected quantitative data from official service statistics and individual client charts. A site assessment was applied to gather qualitative data from clinics.

Results:

Integrating the SDM into service delivery system has provided couples in Benin and Burkina Faso with an additional choice that is contributing to the reduction of unmet need for family planning. The program started in three centers but the SDM is now available in more than 50% of clinics in both counties. Benin and Burkina Faso combined have more than 200 SDM master trainers, over 1000 trained providers and more than 500 community distributors. There are over 10,000 SDM users in these countries. Family planning service statistics provided by the MOH from January 2006 to September 2007 show that SDM users represent 14% of new family planning acceptors. More than 90% of women who choose the SDM have not used a modern family planning method before; others have been dissatisfied with other methods. Almost all women who choose the method do so because it is "natural" and has no side effects[8].

Programs are very satisfied with offering the SDM, and most report that SDM counseling presents an opportunity—and a comfortable context—to encourage and discuss condom use. SDM services have also been integrated into non-health programs including micro-credit and youth programs. Ongoing monitoring suggests that similar results are noted by other partners, and efforts to collect additional evidence continue.

As a consequence of these positive results the MOH of both countries has included the SDM in their national reproductive health norms (Protocoles des services de santé familiale) and in numerous reference manuals.

Conclusions:
The experience of integrating the SDM into family planning and health services in Burkina Faso and Benin suggest that it is an important addition to the method mix. This effective, simple, modern and natural family planning (FP) method has reinvigorated interest in family planning in Burkina Faso and Benin and has repositioned it as a critical component of reproductive health programs. The SDM is now being offered effectively to the community through existing service delivery channels; there is high degree of acceptability and continuation with use of the method; and the SDM is being used correctly and consistently by women in both countries.

References:

[1] Ted Turner's fund. Africa Recovery, Vol.12#1
(August 1998), Briefs page

[2] *Africa's Population Challenge: Accelerating Progress in Reproductive Health*
Africa at the Turning Point, PAI 1998

[3] Carl Haub, 2007 World Population Data Sheet

[4] ORC Macro, MEASURE DHS STATcompiler (www.measuredhs.com,
accessed June 15, 2007).

[5] National Institute for Statistics and Demography NDI 2004

[6] Arevalo M, Jennings V, Sinai I. A fixed formula to define the fertile window of the menstrual cycle as the basis of a simple method of natural family planning. Contraception 2000; 60:357-360.

[7] Arevalo M. Jennings V, Sinai I. Effi cacy of a new method of family planning: the Standard Days Method. *Contraception* 2002; 65: 333-8

[8] Long Term follow-up of SDM clients in Benin and the SDM Site Assessment in Burkina Faso, IRH 2007