

BENIN

Background

Some of the indicators of reproductive health in Benin are quite positive. More than 70 per cent of women seek antenatal care, 62 per cent of whom have had four or more visits per pregnancy. In the capital city of Cotonou, 98 per cent of births are assisted. Even so, 23 per cent of women overall still deliver at home with unskilled traditional birth attendants (TBAs). The **total fertility rate is 5.68** and UNFPA data suggest a **3 per cent prevalence rate of modern method contraceptive use**, as compared to 16 per cent for all methods.⁶ With a C-section rate of 3 per cent, Benin's **maternal mortality ratio is, not surprisingly, very high at 880 deaths for every 100,000 live births.**⁷

Since Benin's democratic elections in 1996, interest in reproductive health policy has emerged. For instance, some legislators are trying to pass a law that prohibits female genital mutilation (FGM) and promotes training those who perform excisions in other skills. Additional features of their proposal involve the improved management of rape cases and therapeutic interruptions of pregnancy. While none of these issues has a direct bearing on fistula in terms of policy, the burgeoning interest in and commitment to reproductive health is evidence of a positive environment in which fistula care takes place.

UNFPA plans to work with providers of fistula surgery in two ways: 1) prevention aimed at improving conditions around prolonged and complex deliveries with rapid diagnosis, better access to hospital care and C-sections and 2) identification of existing cases, actions to reintegrate women into communities and the inclusion of fistula surgery in OB/GYN and urology residencies. **The MOH notes that it is ready to support any action that will lead to the reduction of maternal mortality and morbidity.** Programming for the management of obstetric fistula is included in the national plan for 2002 to 2005.

Benin has made **the reduction of HIV/AIDS a priority**, although prevalence has risen from less than 1 per cent to 4.1 per cent during the past 10 years. HIV/AIDS and malaria have been the health issues given the most attention in Benin, as they are the source of the most illness and death and require frequent interventions. **Fistula has not been acknowledged as an urgent concern.**

Issues and Challenges

The needs assessment team visited four hospitals. National Hospital and University Centre (CNHU); Evangelical Hospital of Bemberéké (where there was one woman who had been repaired and was receiving post-operative care); Brothers of St. Jean of God Hospital; and Zone Hospital of Natitingou (where no fistula surgery is currently performed, although cases have presented at the facility and been referred elsewhere). Two of these are private hospitals and two are public. In addition, the team met with the Atacora and Borgou Departmental Directors of Public Health and with the MOH Direction of Family Health Division. Members of the UNFPA country office also provided background information.

Discussions with UNFPA staff, district administrators and health care workers suggest that **fistula is not yet acknowledged as a critical issue in Benin.** Of the four sites visited, only three offer fistula repair surgery. **Fistula is seldom recorded in provider logs and information on prevalence or incidence has never been gathered.** Many women prefer to go to Niger, Nigeria or Togo for treatment to maintain their anonymity. Most cases are found in the North, where few hospitals exist. It should be noted that some women develop a fistula at a young age; others occur in women who are multiparous. Women may also have had a fistula with a first pregnancy and have been living with the condition for years.

Still, providers only report 80 cases a year, a number they acknowledge is likely to be an

undercount. It should be noted that this is not an exhaustive finding and is only used to give a very general idea of the national caseload, but it may also be true that due to initiatives to improve women's health, the incidence of fistula is lower. On the other hand, in the North, where fistula is most common, FGM is also prevalent, a factor which can predispose women not only to fistula but to maternal mortality. It is, then, possible that women with obstructed labour die before they can reach emergency care.

For the most part, however, **fistula repair has been deemed by some providers in Benin as "luxury" surgery**, since women rarely die from the condition, though they often live as outcasts in their communities. In this way, fistula is perceived as more of a social than a medical crisis. Indeed, many men and women are not aware that fistula is a curable medical problem.

Other traditions practiced in Benin may influence women's decisions to seek treatment. Women afraid to discuss their symptoms in a hospital may consult local healers for help. Some healers, unaware that fistula is a treatable condition, may try to help women overcome their "curse". Consequently, women develop the belief that there is no hope for a cure and, in the process, may exhaust their limited financial resources.

Should women choose to seek repair, only a few local qualified personnel are available to operate and **most facilities visited rely on the services of expatriate doctors.** Sometimes these foreign nationals serve on a continuous basis, but others may only visit intermittently. Although this system has been sufficient to handle the current demand, it is neither a sustainable nor an optimal arrangement. Problems also exist in keeping an adequate provision of supplies. Providers mentioned that it was often difficult to obtain surgical necessities, such as suture material. In the CNHU of Cotonou, the problem affected both fistula repairs as well as general surgery.

However, **other features of Benin's situation could create an excellent atmosphere for the care and prevention of fistula.** For instance,

strong resources for training in surgery and public health exist around the country. The medical school has introduced reproductive health training modules for professors to use during their lectures to medical students in the Certificat d'Etudes Spéciales phase. In addition, **two facilities with the potential to train providers and administrators in aspects of reproductive health have recently opened.** The first is the Regional Institute of Public Health in Ouidah, which offers masters degrees in areas such as epidemiology as well as training in social communication and advocacy, health information systems, vaccinology and infection prevention. Programmes in quality of care and reproductive health were also introduced recently. This centre specializes in research, an invaluable asset for investigating and helping to prevent fistula.

The other facility is a university with a medical school, located in the northern city of Parakou, of particular interest in relation to fistula as that region reports the largest number of cases. This school could be an excellent setting for doctors and students to learn about fistula care and surgery.

Recommendations and Critical Needs

- **Gather qualitative data to better understand the circumstances of clients' lives.**

The Regional Institute of Public Health in Ouidah has the capacity to conduct research to establish a better understanding of how women in Benin live with fistula. With fields of study here including epidemiology and public health, Benin is in a good position to collect information that could illuminate many issues surrounding the condition.

- **Spread awareness of how fistulas occur and what can be done about them.**

National health staff and providers understand the need for this kind of education, but community leaders and policy makers at all levels of government, as well as the kings and queens, must be made more conscious of the problem and how to prevent it.

- **Create programmes that allow women to support themselves financially.**

Fistulas occur in a climate where FGM and low age at marriage predispose women to the problem. The chance for women to earn their own living and learn skills that allow them to do so may improve their social, educational and economic status in Benin.

- **Train local specialists in fistula surgery so services can be offered on a continuous basis.**

Since the majority of fistula service providers are expatriate doctors who either visit intermittently or help a facility with a variety of tasks, it is imperative to train local physicians and medical students. Fistula services need to be sustainable and less reliant on expatriate doctors who may eventually leave.

- **Develop a referral system for fistula services.**

In Benin, information spreads quickly by word of mouth throughout villages and larger towns. Simply by talking about her experience, a woman who has received treatment for fistula can motivate others with the same condition to seek care. But village clinics need more advanced technology, such as a network of radios, to refer cases that involve prolonged labour or other complications.

- **Consider building a model for fistula care at Tanguieta.**

The hospital at Tanguieta, Brothers of St. Jean of God, has had great success. The efforts of its providers suggest it might well serve as a base for regional training. Every year, a provider organizes missions with several collaborators to repair obstetric fistula, and the hospital has now expanded its services to include measures that help prevent fistula as well as cure it. Part of their strategy has involved trying to improve accessibility to remote regions, including the timely evacuation of clients. They have made a 24-hour ambulance available for responses from any of the 14 village clinics connected to the hospital's radio network. However, this initiative is completely funded by donations from

private organizations that key staff members have solicited on their own time. They have submitted a proposal to launch the project in an attempt to make the entire endeavour more sustainable.

Other options might be to designate Tanguieta as an internship site where medical students could get hands-on training in fistula surgery. A video-recording system in the operating theatre would allow them to become better acquainted with surgical techniques.

Fact Sheets on Benin Site Visits

A. CNHU - Centre National Hospitalier et Universitaire (National Hospital and University Centre), Cotonou, visited 1 October 2002

Size: Eight beds in maternity ward, one operating theatre.

Medical staff: Three urologists, of whom one is a professor who no longer performs surgery. Gynaecologists here refer fistula cases to urologists. There are three or four nurses on the surgical team to assist during operations.

Caseload: In 2001, three cases were seen and operated on. Normal yearly average is six. RVF cases are sent to the gastrointestinal surgery team, but these cases have become less prevalent.

Provenance of clients: Most come from Cotonou or other parts of the southern region of the country.

Typical client profile: The typical client is between 18 and 30 years old. Most clients developed a fistula during the course of C-section deliveries and were immediately referred to CNHU for surgery—usually 10 to 14 days after developing the fistula. One woman in recovery at CNHU had been living with a fistula for six years. She had seen several doctors who were not able to diagnose the problem, which could indicate a low rate of prevalence.

Assessment and screening process:

- Consultation.
- Strong odor of urine or faeces is often used as the determining factor.
- Physical examination to determine the size of the fistula.
- Analyses of blood (to check for anaemia), heart, blood pressure, etc.
- If fistula is not immediately recognized upon physical examination, complete x-rays are taken (e.g. for vesicle-uterine fistulas).

Post-operative care:

- Clients are kept in recovery for two weeks.
- Clients are advised to consult a gynaecologist if they would like to have more children.
- Clients are counselled not to get pregnant for at

least two years and to have a C-section if pregnancy occurs.

- Women are scheduled to return in one month to ensure symptoms have not recurred.

Rehabilitation/reintegration: No information.

Community outreach: None known.

Perceived support at the policy level: None known.

Estimated fully-loaded cost per procedure: 10,000 CFA francs (approximately \$14 USD) per day for hospitalization; 126,000 CFA (\$190 USD) for the surgery; and 50,000 CFA (\$75 USD) for pre-operative tests. If a woman is hospitalized for 17 days, which is the average time for fistula clients, the total cost can rise to \$365 USD, not including medication. If the first surgery is unsuccessful and the client comes back for a second attempt, all costs are the same except for the surgery, the price of which goes down to 62,000 CFA (\$90 USD). If a woman cannot pay, either the surgical team will contribute to the costs or she is referred to Tanguieta in the North or to Togo, where a German missionary physician sometimes comes to do surgery.

Resources: None.

Barriers:

- Lack of necessary equipment (stitching thread is often depleted).
- More doctors need to be trained: the surgical team needs strengthening as only two doctors operate.

B. Hôpital de Zone de Natitingou (Zone Hospital of Natitingou), visited 2 October 2002 (hospital visited informally)

Size: Not known.

Medical staff: One midwife performs the majority of deliveries; information on other staff was not available.

Caseload: Five cases in the past three years, none of which were surgically treated. Volunteer doctors who work there have, at times, told the clients that

they are suffering a gynaecological problem that may heal on its own. They are told to go home, but to return if their state does not improve. Only one has returned. All cases have been the result of complications during C-sections and hysterectomies.

Provenance of clients: Rural areas just outside of Natitingou.

Typical client profile: Most women are in their 30s.

Assessment and screening process:

- If a woman says that she no longer has the urge to urinate and that her clothes are always wet, fistula is assumed.
- Speculum is inserted so that clearer image of fistula can be observed.

Post-operative care: Not available.

Rehabilitation/reintegration: Not available.

Community outreach: Not available.

Perceived support at the policy level: Not available.

Estimated fully-loaded cost per procedure: Not available.

Resources: Not available.

Barriers: Not available.

C. Brothers of St. Jean of God Hospital, Hôpital de Zone de Tanguietà (Zone Hospital of Tanguietà), visited 3 October 2002

Size: 250 beds, 40 of which are in the maternity ward. Two operating theatres and special follow-up rooms for post-operative care.

Medical staff: One full-time expatriate physician who performs surgery; two general practitioners, both of whom perform C-sections; one gynaecologist, who comes once a year in April for two weeks to operate on fistula clients; four maternity ward nurses; and three midwives.

Caseload: The majority of fistula surgeries are performed during three specific blocks of time during the year, when the foreign delegation arrives. These missions arrive during the dry seasons because during the rainy season, women, even those with fistula, work in the fields. During each

mission, up to 15 women are operated on. Cases that emerge outside of one of the three periods are operated on by an expatriate doctor, Brother Florent, whose caseload runs to about seven clients a year. Each operation takes on average from four to six hours, depending on the complexity of the fistula.

Provenance of clients: The majority of clients come from Burkina Faso. Others arrive from other parts of Benin, Niger and Togo.

Typical client profile: Usually the women are very poor and developed the fistula with a first pregnancy. They range in age from 13 to 20 years old and are rarely older. However, one doctor remembers a woman in her 50s who had been living with fistula for 25 years before coming for treatment. Most women have been abandoned by their husbands, and many cases are due to complications from C-section or hysterectomy.

Assessment and screening process:

- Client is examined during an initial screening.
- The size and location of her fistula is determined. If the location of the fistula is not immediately obvious, a blue dye is inserted into the bladder to make the path of fluid conspicuous.
- Blood is drawn to prepare for the operation.
- Client is given parasite medication.
- Vitamins and minerals are administered if client is physically exhausted, anaemic or weak. This course of action can last up to two weeks. Once the initial screening process is completed, she is given a specific date upon which to return for surgery.

Post-operative care:

- Client remains in hospital for several weeks to recover.
- She is advised to wait two years before her next pregnancy, but often the timing of subsequent pregnancies is not the client's decision.
- She is also advised that it is necessary to have a C-section in the event of future pregnancies.

Rehabilitation/reintegration: No information.

Community outreach: Brother Florent goes on the radio as often as possible to announce the arrival of the surgery team. Also, the Swiss doctor who

organizes the surgical team missions to Tanguietà has enhanced the exchange of equipment and inter-clinic communication. A 24-hour ambulance is available, and a radio network between the hospital and the 14 peripheral clinics is in place. This facilitates rapid evacuation for emergency obstetric care, a critical tool in preventing fistula.

Perceived support at the policy level: The Beninese government has selected the region surrounding Tanguietà as its first health zone.

Estimated fully-loaded cost per procedure: The cost of the procedure is about 400,000 CFA, just shy of \$600 USD. However, actual costs incurred by women are far less, due to Brother Florent's fundraising initiatives, which have resulted in private organizations giving several donations to the hospital. Because of the subsidies, women pay what they can, in a model that is similar to the idea of a sliding scale. Women usually pay from 20,000 to 80,000 CFA (between \$30 and \$120 USD).

Resources: Three new surgeons have recently been added to the fistula surgery team that comes three times a year. The most recent mission included the filming of an operation, to be included in a documentary that will be used for fundraising purposes.

Barriers:

- Funds. Missionary fundraising efforts are not sustainable.
- Support from Beninese government is openly encouraging but not yet tangible.

D. Hôpital Evangélique de Bemberéké (Evangelical Hospital of Bemberéké), Bemberéké, visited 4 October 2002

Size: 60 beds, three operating theatres.

Medical staff: The operating team includes one expatriate OB/GYN, who volunteers three to four months out of the year; one person with a nursing certificate; and seven hospital workers who have been trained informally by the doctor.

Caseload: Surgeries are carried out three to four

months of the year, when the fistula surgeon is present. Many doctors who have been trained at the centre in Addis Ababa also come at various times during the year. When there is a fistula specialist present, information is spread very quickly by word of mouth, and women appear in higher numbers. The yearly caseload is about 10 to 15 cases. Most operations are successful.

Provenance of clients: Surrounding villages, as well as Niger and Nigeria.

Typical client profile: Clients are under 30 years old, live in the countryside and have typically suffered a very long labour.

Assessment and screening process:

- Client is examined.
- Catheter is inserted to determine location of fistula.

Post-operative care:

- Recovery period is normally considered 10 days.
- Antibiotics are given.
- Women who developed fistula during C-sections are supervised in the hospital for three weeks to see if the wound will heal on its own. Years ago, the physician would insist that the client undergo tubal ligation, because the level of health education (and women's decision-making power) was such that women would not be able to return for follow-up care, and full recovery would not take place.

Rehabilitation/reintegration: Since many clients later return to the hospital for C-sections, it is inferred that they have either returned to their husbands or that they have found new ones.

Community outreach: Word of mouth.

Perceived support at the policy level: None necessary.

Estimated fully-loaded cost per procedure: 30,000 CFA (\$45 USD); most women pay.

Resources: Not available.

Barriers: Not available.

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