

Benin, a West African country nestled between Togo and Nigeria, has a good public health infrastructure. But some of the country's traditional practices, such as early marriage and female genital mutilation, along with malnutrition and illiteracy, put women at risk for fistula. However, fistula is not considered a big problem within the country. Providers report 80 cases a year, which, given other health indicators, is likely to be an undercount.

About one quarter of women overall deliver at home with unskilled traditional birth attendants. Until recently, Caesarean section—the key intervention to prevent fistula in cases of obstructed labour—was not considered an acceptable form of delivery by community members.

While overall improvements in reproductive health are needed, Benin is well positioned to create an excellent atmosphere for the care and prevention of fistula. For instance, the country has strong resources for training in surgery and public health and the medical school has introduced reproductive health training modules. Two facilities with the potential to train providers and administrators in

aspects of reproductive health have recently opened. Even though fistula is not considered an urgent concern, the Ministry of Health is reportedly willing to support any action that will lead to the reduction of maternal mortality and morbidity, and programming for the management of obstetric fistula is included in the national plan for 2002 to 2005.

Four facilities were visited, three of which offer fistula surgery, and discussions were held with UNFPA staff, district administrators and health care workers. Fistula is seldom recorded in provider logs and no information on prevalence has previously been gathered. This is partly due to the aura of shame around the issue.

Women who are 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 qualified local 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 occasionally. Although this system has been sufficient to handle the current need, it is neither a sustainable nor an optimal arrangement.

***The report prepared by UNFPA and EngenderHealth highlighted the following critical needs:***

#### **GREATER AWARENESS FOR PREVENTION**

As fistula is not acknowledged as an urgent concern, advocacy aimed at community leaders and policy makers at all levels of government, as well as traditional leaders, is needed to raise awareness

#### **SELECTED DEMOGRAPHIC INDICATORS**

Total population (in millions)	6.6
Total fertility rate (2000-2005)	5.68
Births per 1,000 women aged 15-19	113
Maternal mortality ratio (deaths per 100,000 live births)	880
Infant mortality per 1,000 live births	81
Per cent births with skilled attendants	60
Contraceptive prevalence rate (any/modern method) (%)	16/3
Secondary school enrolment (M/F)	30/13
HIV prevalence (M/F) (%)	1.18/3.72

Source: UNFPA State of World Population, 2002

about fistula prevention and treatment. Many people in Benin believe it to be incurable. However, information spreads quickly by word of mouth throughout villages and 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.

### ● MORE TRAINED PROVIDERS

Since the majority of fistula service providers are expatriate doctors who either visit intermittently or help out with a variety of tasks, training of local physicians and medical students is needed. Benin already has strong resources for training in surgery and public health, as well as a reputation as a “teaching” country. The country is also well placed to host a regional training centre, and the Brothers of St. Jean Hospital in Tanguiéta has potential in that regard.

### ● BETTER SUPPLIES

Maintaining adequate supplies is problematic. Providers mentioned that it was often difficult to procure surgical necessities, such as suture material. Village clinics also need more advanced technology, such as radio networks, to refer cases that involve prolonged labour or other complications to facilities that can provide emergency obstetric care.

### ● FEWER DELAYS

As Benin is a fairly small country served by several hospitals, transportation appears to be less of an issue than in some other countries in the region. However, better referral systems and evacuation plans are needed to help women in remote areas get timely emergency obstetric care in cases of complicated deliveries.

*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 often perceived as more of a social than a medical crisis.*

### ● IMPROVED DATA COLLECTION

With a maternal mortality ratio of 880, even if only one-tenth of maternal deaths are due to obstructed labour, there must be a greater number of fistulas. More of a focus on record keeping could help to make the case with key policy makers that the issue is a concern.

recognizing the needs in

benin