

NIGER

Background

Nigerien women have the highest fertility rate (8) in sub-Saharan Africa, with a modern contraceptive prevalence rate of 4 per cent and a maternal mortality ratio of 920 per 100,000 live births. Eighty-five per cent of women deliver at home, either unassisted or without the help of a trained provider.²⁸ Entrenched traditions sometimes prevent women from leaving their homes, which may explain why only 30 per cent seek antenatal care and the C-section rate is 2 per cent. In addition, women are invariably encouraged to deliver their first child at the home of their parents, which can result in especially problematic situations when women live in remote areas far from obstetric care.

Other traditions, such as **FGM, which is widespread, put women's health at risk. Of the women with fistula who received repairs in the country last year, 22 per cent had also experienced some form of FGM.** The total number of those with HIV/AIDS in Niger in 2001 was 64,000 and, although no statistics are available for rates of infection among women, it can be assumed that a significant number must also cope with this threat to their health. Early marriage is another common risk factor. Although DHS reports that the average age at marriage for women in Niger is 15, **in certain regions women are married as early as nine years old.** Traditionally, girls are kept in the family home of the man they are to marry and sexual relations are not supposed to begin until the girls reach menarche. Unfortunately, this custom of waiting has slowly eroded.

Young age at first pregnancy also predisposes women to fistula. **Thirty-six per cent of girls ages 15 to 19 have either been pregnant or already have at least one child.** All of these factors have made **obstetric fistula exceptionally common in Niger.** Other conditions further complicate women's health care in this country, including the fact that two-thirds of the nation is desert, 85 per

cent of its population lives in rural areas and illiteracy among women is 91 per cent.

Despite the success of some of its initiatives, the government has not been able to maintain the budget allotted to health and education. NGOs have tried to help offset this situation. CARE Niger organized a workshop in August 2002 for those involved in women's health and rights to discuss issues surrounding fistula in particular. At the workshop's conclusion, participants planned to create a network of people to raise national awareness about obstetric fistula; to organize activities to prevent increased occurrence; and to develop a plan for the 47 women who have waited, sometimes for years, at the National Hospital to receive treatment and begin to reintegrate into the community. UNFPA Niger's programmes include low-risk maternity; a youth initiative, which involves reproductive health for youth and adolescents; and a gender initiative to encourage girls to go to school. The prohibition of early marriage is also featured in this programme. A final project will involve an assessment of the results and effects of these attempts to improve reproductive health.

The local organizations involved in the issue include Reproductive Health for Low-Risk Maternity (DIMOL), an NGO founded in 1998 by a Nigerien midwife who has worked with UNFPA's low-risk maternity initiative. She devised a project to build a fistula operating/treatment centre for which Oxfam-Québec has provided the equipment and supplies. The United States Embassy has funded the construction of the operating block and a hostel for pre- and post-operative clients. The site has been identified and construction of the centre is imminent. Plans to build a well and an apprenticeship studio are also in the works.

The Nigerien Committee on Traditional Practices (CONIPRAT), an NGO which promotes women's health and rights, is working to raise awareness about the dangers of FGM and early marriage, both of which are factors that contribute directly to the

development of obstetric fistula. They recently organized an exhaustive, nationwide survey to take an inventory of the prevalence of these practices, but the results have not yet been tabulated. They are also fighting for legal action that will prohibit early marriage and are promoting activities to reduce FGM by identifying those who perform the procedure and training them in other ways to earn a living. This has worked especially well in Couba, a small southwestern village, whose citizens have come together to expel excisors from Burkina Faso. A legal expert at CONIPRAT has presented a proposal to the Ministry of Justice to pass a national law prohibiting excision. They are currently waiting for the parliament to decide on the matter. The Coordination of NGOs and Feminine Associations of Niger (CONGAFEN) lobbies against early marriage and has solicited local leaders of women's associations for support.

Issues and Challenges

In Niger, the needs assessment team met with staff from the UNFPA country office, who helped to set up meetings with organizations working for women's health and rights, such as DIMOL, CONIPRAT, CONGAFEN, Oxfam-Québec and CARE Niger. The team also spoke with various representatives from specific divisions of the MOH, including the Director of Social Protection and National Solidarity, the Director of Reproductive Health and the Secretary General of Public Health. The team had the opportunity to visit fistula repair sites at Niamey National Hospital the University Hospital of Lamordé, the District Hospital of Loga, Zinder Maternity Hospital and Maradi Regional Hospital. Several facilities housed fistula clients who had recovered from surgery and were available for interviews. At the Niamey National Hospital, the team had the chance to speak with the group of 47 women living in the fistula repair pavilion.

Visits to five sites and discussions with providers, district officials and NGO staff indicate that, as noted, **obstetric fistula in Niger is an extremely common phenomenon**. Its occurrence is frequently linked to traditional practices preva-

lent in the rural areas where most fistula cases develop. **A national survey conducted by two fistula surgeons in 1995 to acquire a clearer picture of the issue found that the average age of those polled was 13, and 58 per cent were primigravidus.**

Cultural concerns appear to be paramount in keeping women from receiving care before, during or after a birth. In some villages near the Nigerien border, women are not allowed to leave their homes at all and receive guests through a veil, which suggests that they are not likely to seek antenatal or emergency obstetric care. In addition, very young women who are pregnant for the first time often refuse antenatal care out of shame. Because little community support exists for such treatment, if these women suffer a complication during labour, they may turn to a local religious healer or an untrained older woman. The women receive no financial support from their husbands, who sometimes will not let them obtain assistance from a trained provider.

A range of traditional practices can put women at risk for fistula. In some parts of the country, the practice of giving women water to drink to expel the baby during labour can lead to fistula, given that the baby's head pushes against a full bladder. A custom known as cervical repositioning involves putting a wooden spatula into the vagina if a woman experiences infections during pregnancy. It is said that her vagina has fallen and that the spatula will restore it to its correct position. TBAs may also press their elbows or knees on a woman's belly to keep the baby from being expelled through the anus.

Should a fistula develop and a woman decide to seek care, her choices will be few. **In general, surgical resources for fistula repair are spotty. At the three sites that provide these services in Niger—Niamey, Maradi and Zinder—only six surgeons are known to have the technical abilities to handle fistula repair.** Three of the six received some background in the procedure in Addis Ababa, and of the remaining three, one is known not to have had technical training and is

unable to repair complicated fistulas.

More providers are desperately needed, as the current supply does not meet the demand. A sizable backlog of clients exists, especially in Niamey, where fistulas that are difficult to repair are referred. Training is feasible within the country from the few specialists who have been trained in Addis Ababa, but providers must be made aware of the most updated surgical techniques. In addition, staff are reluctant to stay in certain locations because life in the “brush” is very difficult, as most of the remote villages are in the midst of the desert.

Even if women do undergo a successful repair, they may not return to their husbands. Most are illiterate and lack skills for employment. Some turn to commercial sex work once their fistula is closed as a way to earn an income. This situation is of particular concern in crossroads cities, such as Dirkou in the northern Sahara, which is frequented by business travellers from various countries with high HIV/AIDS prevalence rates.

Two other projects linked to government involvement also illuminate the situation. As a response to a national need for self-sufficiency, the President of the Republic inaugurated a programme to build schools, reservoirs of clean water and local health units staffed with a midwife and a nurse in 1,000 of Niger’s 9,000 villages. While 85 per cent of the project has been completed, the schools and dispensaries have had difficulty retaining health care workers in the most distant settings. An initiative funded by the World Bank and some partners mirrors this outcome: in 1995, 30 hospitals were constructed, all well equipped to handle emergency cases. Many of these, however, suffer from a lack of qualified personnel and often do not offer sufficiently attractive salaries to retain well trained staff. More positively, a division of the MOH now pays for C-sections needed by women who have had fistula repair.

A final example involves a programme intended to address obstetric fistula directly. After the 1995 survey, a project was designed to

treat current and prevent future cases of fistula over the course of four years. Called Prévention et Traitement de la Fistule Obstétricale au Niger (the Prevention and Treatment of Obstetric Fistula in Niger), its strategies included building national and regional teams of doctors trained in fistula, educating providers, rebuilding hospital infrastructure and spreading information, education and communication about the topic to the population, all at a cost of \$385,000 USD. While the government found that the programme was useful, it was not able to provide financing for the launching of the work. La Coopération Française took on the task and proposed activities were carried out over a three-year period.

Recommendations and Critical Needs

- **Provide better and more training to more fistula repair providers, with a focus on remote locations.**

This process may involve integrating emergency obstetric care into the training for fistula surgery, since part of the issue in Niger involves keeping qualified providers in remote areas where mastery of emergency techniques is of critical importance. But an effort must also be made to increase the sheer number of providers to better address the caseload of women already waiting for repairs. Work should be done, too, to improve health care workers’ treatment of women with fistula, who sometimes are referred to as “those women who smell of urine.” Finally, it may be necessary to implement some kind of incentive system for providers, such as adequate housing, better salaries, improved communication and transportation and/or the opportunity for continued education.

- **Create and disseminate community awareness campaigns.**

Advertising aimed at village chiefs and religious leaders, as well as TBAs and pregnant women, could counteract the notion that delivery becomes problematic only after the second or third day of labour.

These campaigns would need to be in local languages and aired via radio, television and newspapers. It would be extremely effective to involve former fistula clients in these efforts on a national and district level.

- **Organize better transport and communication between health care sites.**

Transportation to appropriate care may be an obstacle. Women may have to travel by wagon or donkey if they are not picked up as hitchhikers. If they find an ambulance, they have to pay for gas. District hospitals urgently need more vehicles and a better radio network for referrals.

- **Explore ways to help make fistula clients more economically self-sufficient.**

Helping women learn new skills is a good means of assisting them after surgery and may prevent them from turning to more desperate measures, such as commercial sex work, as a way to earn a living.

- **Increase contact between funders and clinicians.**

Frequently, NGOs and foundation personnel negotiate with administrators and officials instead of with those directly implementing programmes, leading to projects getting stalled at the planning stage. Increasing communication between funders and those caring for fistula clients would help both parties to plan.

- **Advocate for increased funding for national projects.**

For Niger to be able to safeguard maternal health, more financial and political backing of projects aimed at preventing the decline in women's health, and improving their social and physical status, are needed in the country.

- **Consider creating a fistula centre at Hôpital de Lamordé.**

Because of the interest and commitment of the chief urologist and the fact that this hospital is currently receiving all of the urology cases in the

region surrounding Niamey, it is a strong candidate to become a fistula centre. The chief urologist was trained in Addis Ababa and is now eager to train other local physicians.

Fact Sheets on Niger Site Visits

A. Hôpital National de Niamey (Niamey National Hospital), visited 8 October 2002

Size: 244 beds for the surgery ward, with 20 beds reserved for fistula clients. Six operating theatres, one of which is used for fistula operations.

Medical staff: 15 surgeons, including expatriates; seven medical assistants; several nurses and anaesthesiologists who rotate through different departments. Dr. Amadou Deibou performs surgery on an increasingly small caseload each year (see below.)

Caseload: In 2000, there were 92 admissions; 51 of these women underwent surgery. In 2001, 23 were admitted, and this year, 10 have been admitted. The reason for the decrease in numbers is the restructuring of three area hospitals; all clients with urological issues are now seen at one central hospital, Lamordé.

Provenance of clients: Mostly departments of Tillabéry, Dosso (a central crossroads city, also a department) and all over Niamey.

Typical client profile: It depends on how long the client has had the fistula. If she is being seen just a few weeks after the fistula has developed, she is usually depressed, limping due to partial paralysis from labour complications, in wet skirts and usually smelling of urine and/or faeces. If it has been several months after the fistula has developed, the client has had time to take control of the leaking, by wearing pads or other forms of protection. These women are often also very depressed after the still-birth of their child. Eighty per cent of the women have been married by age 16 and have become pregnant by age 18. The fistula typically has developed in that time. Clients are usually accompanied by their mothers, rarely by their husbands.

Assessment and screening process:

- Physical exam is done.
- Clinical assessment done (blood type determined, blood count taken to check for anaemia).
- Electrocardiogram.

- Sometimes x-rays are taken, if necessary.
- Type and dimensions of fistula are also determined.

Post-operative care:

- Clients are hospitalized for 10 to 14 days after the operation.
- A catheter is inserted to make sure urine exits through the catheter and not from the vagina; client is observed to ensure no further complications arise.
- Antibiotics given.
- Advised to abstain for at least two months, and to return to the hospital if they get pregnant to seek antenatal counselling and care from the gynaecologist. They are told to make sure their next birth occurs in a hospital setting.

Rehabilitation/reintegration: None noted.

Husband almost invariably takes them back once fistula is closed.

Community outreach: Women's NGOs intervene at various levels.

Perceived support at the policy level: The Ministries of Public Health and Social Development organize visits to see fistula clients. They also make efforts to sensitize others by visiting centres with members of national NGOs and sometimes with members of embassies, including Canada, France and the United States. These visits usually result in donations of food and clothing.

Estimated fully-loaded cost per procedure:

\$55 USD is the quoted price, fully loaded is likely to be more.

Resources: Costs of procedure (hospitalization, operation and medication) used to be fully funded by a French cooperative, Falandry, which received more than \$150,000 from the French government some years ago. The money has since been exhausted, and women now pay for the procedures themselves, financing it any way that they can.

Barriers:

- Before intervention from CARE Africa in the form of a fistula workshop, doctors worked alone, with-

out support of others doing the same repairs. The situation is somewhat better now that there is more collaboration.

- Financing for repairs must be made available. Initiatives to advocate for funds for fistula repair need to be in place.

Additional Notes on Niamey National Hospital Fistula Pavilion

This situation is a very special case. In an isolated part of the hospital grounds a pavilion holds about 50 women, many of whom who have been waiting for several years to be treated. These women live within the walls of this enclave, where they are ostracized by other female residents of the hospital, who consider them to be unclean. They all have fistula, some for the second or third time. They are all waiting for help. They are all waiting to go home.

In 1994, a French surgeon received funding for a project to treat women with obstetric fistula. As he had not mastered the surgical techniques of such a procedure, many attempts failed. When funding for his project was exhausted, he left the country, while these women, who had either had botched operations or none at all, were trapped. The pavilion at the Niamey National Hospital was designated as a place to keep them so that they would not have to live in the streets. To date, they have still not been treated because they have no money to pay for the surgery.

It was remarkable to talk with these women, who, despite the suffering they live with every day, laugh and remain hopeful that they will one day be able to lead normal lives again. One recently broadcast radio programme labelled them as totally abandoned, without family and friends, tired and depressed; but in reality, most of them have family whom they visit occasionally. They are taught various activities to pass the time. They cook for each other, sew and braid each other's hair. They live together, waiting.

Encouragingly, the NGO DIMOL has received funding from Oxfam-Québec to build a fistula repair centre in Niamey. Construction has not yet begun, but they have taken action to begin financ-

ing surgery for the women at the pavilion. Operations, which will take place at Lamordé and at the National Hospital, are scheduled to begin in November 2002.

B. Hôpital de Lamordé (Lamordé Hospital), visited 8 October 2002

Size: 72 beds, six of which are reserved for fistula clients; two operating theatres and one recovery room.

Medical staff: Dr. Oumourou Sanda, the head fistula surgeon, leads a team of five surgeons, including two urologists, one general surgeon, one pediatric surgeon, and one trauma surgeon. Six surgery nurses and 11 hospitalization nurses, four of whom are involved in post-operative care. **Caseload:** Three to four operations per week, and as many as 200 per year. Last year, there were about six cases of RVF. However, on 7 October 2002, Dr. Sanda operated on a nurse from a hospital in Zinder, a large city in the southeastern part of the country. She had both VVF and RVF. She was operated on in Zinder, and the VVF was repaired. But when they tried to repair the RVF, four attempts proved unsuccessful. She was then referred to Lamordé where the RVF was repaired.

Provenance of clients: All over the country. Some from Burkina Faso, Mali and Nigeria. Most Nigerien women are from the department of Tillabéry, because Lamordé is easy to get to from there. There are also referrals from the maternity hospital in Niamey. Women are put on a waiting list to receive service. There is a huge backlog.

Typical client profile: Impoverished, the majority (89 per cent) are illiterate; most are housewives with an age range of 15 to 35. It was explained that the older cases are usually of very high parity, resulting in fragile uteruses that rupture during pregnancy or labour. Most women are accompanied by their mothers, a sister or an aunt. Almost all are divorced, which in Niger does not consist of paperwork and lawyers but rather a separation.

Assessment and screening process:

- Standard clinical assessment; the urinary area is sterilized in preparation for the procedure in case of infection.
- Operation is then scheduled.
- Blood type is determined.
- Other tests performed if needed.

Post-operative care:

- A catheter is inserted for two weeks, and clients are observed. The catheter is then removed to check for incontinence. If a woman continues to be incontinent, she is watched closely for about a week. Sometimes, this is enough time for the wound to continue healing on its own.
- Clients are counselled by a social worker about contraception, what to do in the event of future pregnancies and to abstain from sexual relations for three months.
- Clients are advised to return in three months to consult with the urologist, who asks them if they want to return to their husband. Most choose not to go back because they are hurt and angry about being abandoned. Some women do not return for a consultation after the three months, and later get pregnant again, deliver at home again and return to the hospital, their fistula reopened. Of these cases, there is a 16 per cent failure rate.

Rehabilitation/reintegration: Only the help of the social worker, who counsels them and answers any questions clients may have.

Community outreach: The European Union runs a social service that gives affidavits to women who cannot afford the procedure. This helps some women.

Perceived support at the policy level: None. It was explained that to date no one from the government has visited the site, or acknowledged the work being done there. Members of the surgical team are concerned because Niamey National Hospital receives support. However, at Lamordé, where the caseload is larger, there is no support at all.

Estimated fully-loaded cost per procedure: 30,000 CFA, about \$45 USD. Women also pay 2,500 CFA, approximately \$4 USD, for a hospitalization of up to one month, sometimes more. Clients pay for their own medications.

Resources: Support from the state, which covers salaries; internal resources, which is income generated from clients; and donations from various sources.

Barriers:

- Lack of political support. The work they are doing needs to be better recognized on a national level so that specific initiatives can be taken by the government to help clients and the providers who treat them.
- Insufficient medication and equipment.
- Inadequate facilities. Designating or constructing a new building exclusively for fistula clients would help alleviate the current backlog.
- Bureaucratic slowdown. Any outside funding propositions or programme plans need to be presented directly to the clinicians in charge, who understand and manage the situation day to day. Too often when plans are made by administrators, the information stays at the top and does not involve those whom the plans directly affect.

C. District Sanitaire de Loga (District Hospital of Loga), visited 10 October 2002

Size: 28 beds; two operating theatres, only one of which is currently functional.

Medical staff: 18 in total, including two doctors, though only one OB/GYN, Dr. Moustapha Diahllo, does fistula repair; two midwives; one medical/surgeon's assistant; one anaesthetist; and three laboratory technicians. The rest are nurses and contractual workers.

Caseload: Not very large. Since November 2001, only three cases have been seen. Because the operating theatre is not always usable, many women are not aware that fistula repair can be done here. The surgical team spoke with a woman named Barakatou who was married at 17 and developed fistula at 20. She claims that there are many women in the region who are suffering, but don't know that they can be cured at Loga. Many of them have no home life and live as she did before having her operation. Being abandoned by her husband pushed

her to seek help. She was repaired, returned to her husband, got pregnant several months later and came to Loga to have a C-section.

Provenance of clients: They come from the villages surrounding Loga. In one case, a woman who was in prolonged labour at one of the *cases de santé* (health huts) was brought by ambulance (provided for by UNFPA Niger) because that hut had radio contact with the district hospital.

Typical client profile: Most are housewives whose husbands are agriculturists. They are very young. Only in one of the three cases mentioned above was the woman separated/divorced from her husband. Another one of the women had fistula for 10 years and her condition was too complicated to repair. She was referred to Niamey.

Community outreach: Information is usually spread by word of mouth. UNFPA finances certain awareness campaigns. For example, these campaigns may include meeting with women in the community to give them health messages about HIV, immunizations or available delivery services.

Perceived support at the policy level: None.

Estimated fully-loaded cost per procedure: The cost quoted was the same as for other operations, about \$15 USD. This amount covers all costs.

Resources: Federal funding. UNFPA provided funding to construct the new operating centre and also provides technical assistance such as supplies and training.

Barriers:

- Existing personnel need to be trained. The doctor who currently performs fistula repair does not operate on complex fistulas, but refers them to Niamey. If he and a surgical team were trained properly, this delay would not be necessary.
- A system needs to be in place to inform the community that fistula repair is possible at Loga.
- The current budget is not sufficient for necessary supplies such as suture materials, anaesthesia and oxygen.
- Lack of space. There are only eight beds—four for women and four for men—available for recovery. More beds are necessary, especially in the event that more fistula cases arrive.

D. Maternité Centrale de Zinder (Central Maternity Hospital of Zinder), visited 11 October 2002

Size: 45 beds; one operating theatre specifically for fistula repair, which was converted from some sort of examination room; one delivery room. A new fistula treatment centre funded by La Coopération Française and located next door was constructed in 2001. However, because the operating equipment ordered has not yet arrived from Europe, the centre is not yet running. Fistula repair is currently performed in the maternity hospital.

Medical staff: 60 agents: two OB/GYNs, six midwives, two anaesthesiologists and one medical/surgery assistant, with the remainder being nurses and laboratory technicians. Both Dr. Lucien Djangnikpo and his associate have been trained in fistula repair at the Katsina Centre in Nigeria.

Caseload: According to Solidarité, the NGO created by health providers at the maternity hospital to mobilize funding for the new fistula centre, 259 surgeries were performed between 1998 and 2001. There are an estimated 10,000 cases nationwide. However, it is thought that the actual number is much higher: as many as 25–30 per cent of Nigerien women with fistula go to Nigeria to be treated.

Provenance of clients: Mostly from the region of Zinder (32 per cent); some are from Nigeria. There are also some women who come from the Diffa and Maradi regions of Niger.

Typical client profile: Women who live in rural zones make up 90–100 per cent of the cases that are seen. Most are younger than 17 and are primigravidae. The surgeons have operated on some women who have undergone FGM. Two years ago, one young woman, her name unknown, came to the hospital to receive treatment for her first fistula, which developed when she was fifteen. She had been abandoned by her husband and had spent over a year looking for help. After her recovery, her family pushed to get her husband to take her back. He did, but he had already taken another wife. She rejoined the family as the second wife and got pregnant shortly after. Although advised during her post-operative care to return to the hospital during

the seventh month of her next pregnancy to prepare for a C-section, she could not come because her husband had travelled and had not returned. When she delivered at home, labour complications ensued and a fistula once again occurred.

Assessment and screening process:

- Exam conducted to determine that fistula is the source of the incontinence.
- The fistula's location assessed, and its type and size are determined.
- Clients are examined using instruments that are exposed to open air.
- A catheter is inserted as soon as a diagnosis has been made. If the fistula developed less than three months earlier, it is possible to see a significant reduction or total closure approximately one week after the catheter is inserted.
- The operation is performed vaginally; no abdominal cutting is necessary.

Post-operative care:

- Clients remain in the hospital for at least one month.
- The catheter remains in during this period. Clients are instructed by the OB/GYN to drink lots of water so that there is a continuous stream of urine through the catheter inserted after surgery and left in for four weeks. According to the surgeon, this practice reduces the likelihood of infection and removes the need for antibiotics (despite information that the risk of infection increases 10 per cent every day the catheter is left in over seven days).
- No antibiotics are administered during the post-operative phase.
- Personal hygiene of the vaginal area is recommended.
- Removable sutures are left in for four weeks, after which they are removed without anaesthesia.
- Despite the presence of 26 beds in a newly constructed fistula centre, women recover in a shed outside the hospital. Mats on the floor serve as places to sleep.
- Six months of abstinence is recommended.
- Clients are advised to return during the seventh month of their next pregnancy to receive

antenatal care and to prepare for a C-section.

Rehabilitation/reintegration: An action plan written by Solidarité specifies that these services will be provided for women who have been treated at the fistula centre. They have yet to start, however, since the centre is waiting for the arrival of equipment before initiating any of these kinds of activities. The centre also hopes to train women in a skill that will allow them to provide for themselves. Women who have had fistula for 10 to 15 years are likely to have lived in terrible shame and may resort to commercial sex work once they are repaired as a way to seek an immediate income to survive.

Community outreach: A lot of outreach is done on the radio, with the message that fistula is a repairable problem broadcast in local languages.

Perceived support at the policy level: Local officials are aware of the problem. The mayor of Zinder donated the land for the new fistula centre. Zinder's Sultan visits often, as does the First Lady.

Estimated fully-loaded cost per procedure: Solidarité covers the cost of the entire procedure. Costs to the hospital listed in the action plan budget include: room and board, \$750 USD a year; client reinsertion at \$15,000 USD a year; and medications at \$23,400 USD a year. Given that the number of cases treated a year is roughly 75, it can be estimated that the cost for a single procedure would run to about \$750 USD, although the surgery is free to clients.

Resources: Solidarité. No state subsidy. They want to see the centre integrated in the state budget.

Barriers:

- They are still at the beginning. The centre is not yet operational, though its beds could be used for women in recovery. Currently, clients recover in an open shed outside the hospital and sleep on mats.
- Staff could receive updates on infection prevention practices, such as the development of a protocol on the use of post-operative antibiotics and the maintenance of a sterile field in the operating theatre.

E. Hôpital Regional de Maradi (Regional Hospital of Maradi), visited 13 October 2002

Size: 330 beds, 14 of which are reserved for post-operative care; three operating theatres, one of which is reserved for fistula surgery.

Medical staff: 143 agents, 81 of whom are medical professionals. One Nigerien surgeon and three Chinese surgeons, one of whom performs fistula repair. According to Dr. Ousseini Boulama, the Hospital Director, there are no local fistula surgeons at the moment. Providers from the Katsina centre in Nigeria were frequent supporters, coming twice a week to help with fistula operations. Because of some difficulties, however, the Katsina physicians stopped coming. They are expected to return after this season's harvest.

Caseload: During the first half of 2002, only one case was operated on. When the Nigerians were assisting the staff in Maradi, the caseload was much higher. In 2001, 17 cases were seen and not all were operated on.

Provenance of clients: Women come from all over the region and also from Nigeria, whose border is 70 km away.

Typical client profile: Young, usually abandoned by their husbands. They are often hopeless and alone, as they may also have been abandoned by their families. They are often malnourished; however this is not necessarily specific to the women who come for fistula repair, as it is not unusual for Nigerien women to be undernourished. Many have undergone FGM as excision is very common in the region of Maradi.

Assessment and screening process:

- Surgery is usually performed during the week that a woman arrives.
- A general clinical assessment is done.

Post-operative care:

- Clients generally remain at the hospital for three to four weeks.
- During this time, client hygiene is monitored, antibiotics are given and the catheter is checked every morning to make sure it is not leaking or blocked. It is possible to inject blue ink into the

bladder in the case of leaking to determine where the leak is coming from.

- Clients are also encouraged to get up and walk around every day to regain muscular strength.

Rehabilitation/reintegration: None noted. There is no problem of reinsertion after the fistula is closed, but the hospital does not intervene at that level.

Community outreach: A forum of village chiefs and religious leaders organized by UNICEF was held to raise awareness about the need to fight against early marriage. The hospital recommended that a committee be created at a political level to manage such an effort, but to date nothing has been done.

Perceived support at the policy level: Not available.

Estimated fully-loaded cost per procedure: The operation is free. Women pay for their own medications.

Resources: Only the state support that is required for a regional hospital.

Barriers:

- Must find a way to help the hospital pay for medications, which would substantially relieve financial pressure on clients seeking care.
- Women often go back to their husbands because they cannot support themselves. Training in income-generating skills at the hospital might help clients make post-operative decisions out of personal choice, not economic need.
- No community level investment in the importance of antenatal care. Women who are very young and forced to marry are often ashamed to show their pregnancy in the village and resort to staying home instead of consulting health professionals for antenatal recommendations.
- UNICEF did a study in 1998 to see why so many women were still delivering at home, and the results showed that: 1) Women are cloistered at home for religious reasons; 2) They receive no financial help from their husbands to seek hospital care; 3) Socially, the subordinate position of women makes it difficult for them to make their own decisions; and 4) They were ashamed to emerge pregnant in the village.

Key Contacts

The needs assessment team is deeply grateful to the following individuals in Niger for their assistance with this project.

UNFPA Country Office

Nathalie Maulet, UN Volunteer

Ministry of Health

Mr. Issa Boubacar, Director, Division of Social Protection and National Solidarity

Dr. Adamou Hassane, Director of Public Health

District Hospital of Loga

Dr. Moustapha Diahllo, OB/GYN

Issaka Gazobi Maternity Hospital of Niamey

Dr. Madi Nayama, Chief OB/GYN

Lamordé Hospital

Dr. Oumourou Ganda, Head Urologist and fistula surgeon

Mr. Adoumou Aziz, Head Nurse

Mr. Salifou Boubacar, Head Surgical Nurse

Dr. Fatima Djaharou, Anaesthesiologist

Dr. Amadou Soumana, Assistant Urologist

Maradi Regional Hospital

Dr. Ousseini Boulama, Hospital Director

Niamey National Hospital

Dr. Amadou Seïbou, Chief Surgeon

Zinder Central Maternity Hospital

Dr. Lucien Djangnikpo, Chief OB/GYN

DIMOL

Ms. Salamatou Traoré, President

CARE Niger

Mr. Omar Tankari, Coordinator, Civil Society and Education Sector

CONGAFEN

Ms. Maémouna Niendou, Permanent Secretary

CONIPRAT

Ms. Ouassa Djataou, Vice President

OB/GYN Society of Niger

Dr. Nafio Idi, President

Oxfam-Québec

Ms. Fatima Ibrahïma, Organizational Adviser of Development

Solidarité

Ms. Hadizhatou Ibraïm, Vice President