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# REPRODUCTIVE HEALTH *at a* GLANCE

# BENIN

April 2011

## Country context

Benin's per capita income of US$750[1] and the country's sustained growth rates averaging 4.7 percent annually during the last decade, resulting in modest increases in its per capita income (US$750) as well as improvements in human development.[2] Nevertheless, poverty remains widespread, with 47 percent of the population still subsisting on less than US $1.25 per day,[3] and the economy remains undiversified and vulnerable to external shocks.

Benin's large share of youth population (43 percent of the country population is younger than 15 years old[3]) provides a window of opportunity for high growth and poverty reduction—the demographic dividend. For this opportunity to result in accelerated growth, the government needs to invest more in the human capital formation of its youth. This is especially important in a context of decelerated growth rate arising from the global recession.

Gender equality and women's empowerment are important for improving reproductive health. Higher levels of women's autonomy, education, wages, and labor market participation are associated with improved reproductive health outcomes.[4] In Benin, the literacy rate among females ages 15 and above is 28 percent.[3] Fewer girls are enrolled in secondary schools compared to boys with a 57 percent ratio of female to male secondary enrollment.[3] Two-thirds of adult women participate in the labor force[3] that mostly involves work in agriculture. Gender inequalities are reflected in the country's human development ranking; Benin ranks 145 of 157 countries in the Gender-related Development Index.[5]

Greater human capital for women will not translate into greater reproductive choice if women lack access to reproductive health services. It is thus important to ensure that health systems provide a basic package of reproductive health services, including family planning.[4]

## Benin: MDG 5 status

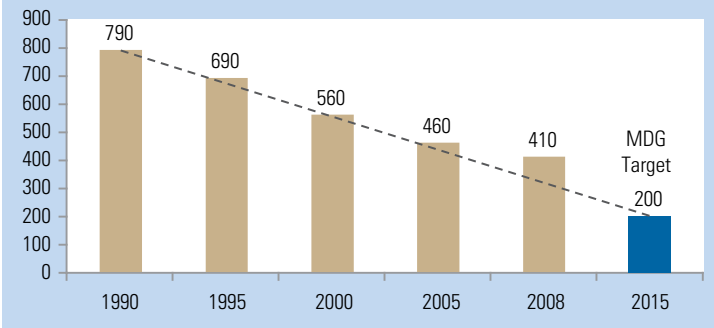
| MDG 5A indicators | |
|---|---|
| Maternal Mortality Ratio (maternal deaths per 100,000 live births) *UN estimate*[a] | 410 |
| Births attended by skilled health personnel (percent) | 77.7 |
| **MDG 5B indicators** | |
| Contraceptive Prevalence Rate (percent) | 17.2 |
| Adolescent Fertility Rate (births per 1,000 women ages 15–19) | 112 |
| Antenatal care with health personnel (percent) | 88.0 |
| Unmet need for family planning (percent) | 29.9 |

*Source:* Table compiled from multiple sources
[a] 2006 DHS estimated MMR at 397 per 100,000 live births.

## MDG Target 5A: Reduce by Three-quarters, between 1990 and 2015, the Maternal Mortality Ratio

Benin has been making progress over the past two decades on maternal health but it is not yet on track to achieve its 2015 targets.[6]

**Figure 1 ▪ Maternal mortality ratio 1990–2008 and 2015 target**




Source: 2010 WHO/UNICEF/UNFPA/World Bank MMR report.

## World Bank support for Health in Benin

The Bank's current ***Country Assistance Strategy*** is for fiscal years 2009 to 2012.

**Current Projects:**
P096482 BJ-Malaria Cntrl Booster Prgm SIL (FY06) ($31m)
P113202 BJ-Health System Performance proj (FY10) ($33.8m)

**Pipeline Project:** P121534 BJ: Strengthening EpidemiologicalSurveill PCN date 11/30/2010

**Previous health projects:** P073118 BJ-HIV/AIDS Multi-Sec APL (FY02)
P096193 BJ-IDF Female Genital Mutilation (FY06)

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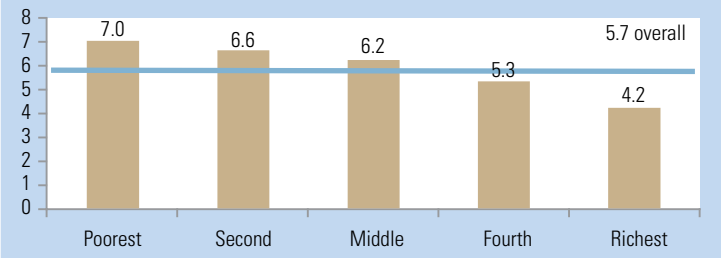
## Key challenges

### High Fertility

**Fertility has been declining over time but remains high, especially among the poorest.** The total fertility rate (TFR) has fallen from 6.3 births per woman in 1996 to 5.7 in 2006.[7]

**Figure 2 ▪ Total fertility rate by wealth quintile**



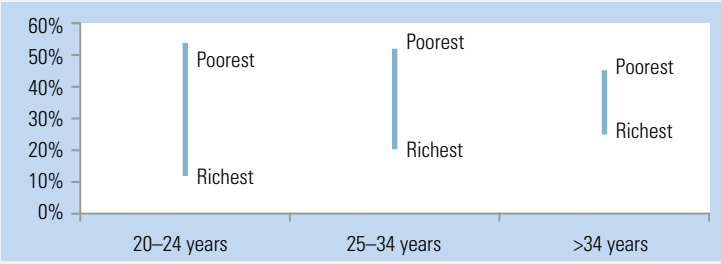

*Source: DHS Final Report, Benin 2006*

Wide disparities exist with the fertility of women in the lowest wealth quintile being almost twice that of women in the highest wealth quintile (7.0 and 4.2 births per woman, respectively)[7] (Figure 2). Similarly, while TFR is 3.4 among women with secondary education or higher, TFR reaches 6.4 among women with no formal education.[7]

**Adolescent fertility rate is high (112 reported births per 1,000 women) affecting not only young women and their children's health but also their long-term education and employment prospects.** Births to women aged 15–19 years old have the highest risk of infant and child mortality as well as a higher risk of morbidity and mortality for the young mother[4, 8].

**Early childbearing is more frequent among the poor**. While 54 percent of the poorest 20–24 years old women have had a child before reaching 18, only 11 percent of their richer counterparts did (Figure 3). Furthermore, reduction in early childbearing mostly has taken place among the rich where younger cohorts of girls are less likely than older cohorts to have a child early in life.

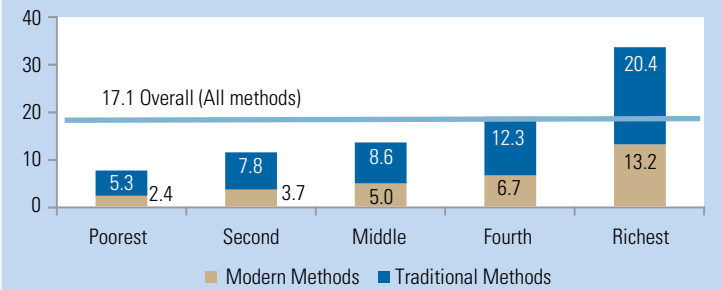
**Figure 3 ▪ Percent women who have had a child before age 18 years by age group and wealth quintile**




*Source:* DHS Final Report, Benin 2006 (author's calculation).

**Less than a fifth of women use contraception.** Current use of contraception among married women was 17 percent in 2006[11] percent traditional methods and 6 percent modern contraceptive methods).[7] Injectables are the most commonly used modern method. Use of long-term methods such as intrauterine device and implants are negligible. There are socioeconomic differences in the use of modern contraception among women: it is high among women with secondary education or higher (19 percent), urban women (9 percent) and women in the in the wealthiest quintile (13 percent)(Figure 4).[7]

**Figure 4 ▪ Use of contraceptives among married women by wealth quintile**




*Source:* DHS Final Report, Benin 2006

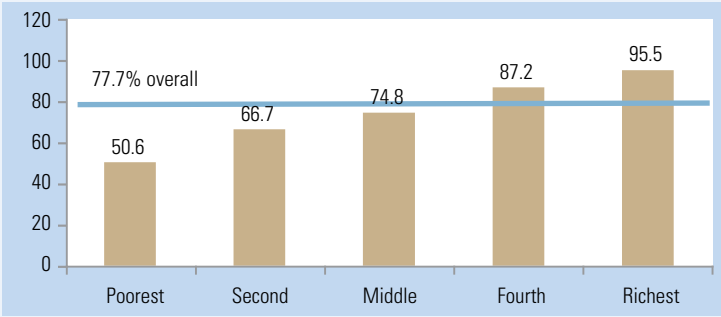
**Unmet need for contraception is high at 30 percent[7] indicating that women may not be achieving their desired family size.[9]**

**Health concerns (22 percent) and opposition to use (20 percent) are the predominant reasons women do not intend to use modern contraceptives in future.[7]**

### Poor Pregnancy Outcomes

**Majority of pregnant women use skilled health personnel for antenatal care and delivery.** Nearly nine-tenths of pregnant women receive antenatal care from health personnel (doctor, nurse, midwife, or auxiliary wives) with 61 percent having the recommended four or more antenatal visits.[7] Further, 77 percent of pregnant women deliver with the assistance of health personnel, with the majority being assisted by a nurse or midwife (69 percent) mostly in public facilities.[7] While 96 percent of women in the wealthiest quintile delivered with skilled health personnel, 51 percent of women in the poorest quintile obtained such assistance (Figure 5).

**Figure 5 ▪ Birth assisted by health personnel (percentage) by wealth quintile**




*Source:* DHS Final Report, Benin 2006

Nevertheless, 73 percent of all pregnant women are anaemic (defined as haemoglobin < 110g/L) increasing their risk of preterm delivery, low birth weight babies, stillbirth and newborn death.[10]

**Nearly three-quarters of women who indicated problems in accessing health care cited concerns regarding inability to afford the services** (Table 1).[7]

**Table 1 ▪ Barriers in accessing health care (women aged 15–49)**

| Reason | % |
|---|---|
| At least one of the problems for accessing health care | 84.6 |
| Getting money for treatment | 73.9 |
| Too costly | 56.7 |
| Distance to health facility | 38.1 |
| Having to take transport | 36.6 |
| Too long of a wait | 30.4 |
| Personnel absent or late | 29.2 |
| Care received not good | 24.2 |
| Poor reception | 23.6 |
| Not wanting to go alone | 21.6 |
| Knowing where to go | 18.3 |
| Concern no female provider available | 16.0 |
| Getting permission to go for treatment | 14.9 |

*Source:* DHS final report, Benin 2006

**Human resources for maternal health are limited** with only 0.14 physicians per 1,000 population but nurses and midwives are slightly more common, at 0.60 per 1,000 population.[11]

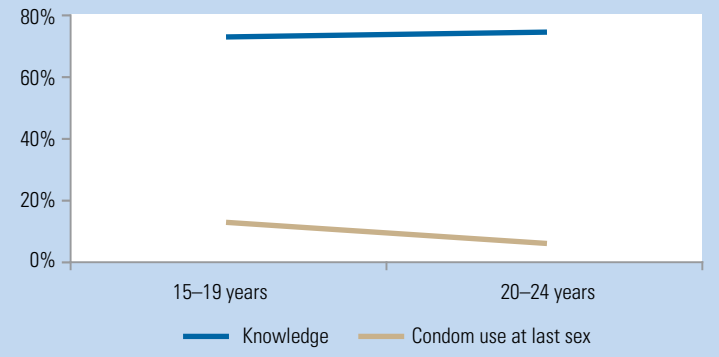
The high maternal mortality ratio at 410 maternal deaths per 100,000 live births indicates that access to and quality of emergency obstetric and neonatal care (EmONC) remains a challenge.[6]

## STIs/HIV/AIDS prevalence is relatively low but a growing public health concern

The percentage of adult population aged 15–49 years who have HIV is 1.2 percent.

**There is a large knowledge-behavior gap regarding condom use for HIV prevention.** While most young women are aware that using a condom in every intercourse prevents HIV, only 13 percent of them report having used condom at last intercourse (Figure 6). This gap widens among older aged women.

**Figure 6 ▪ Knowledge behavior gap in HIV prevention among young women**




*Source:* DHS Final Report, Benin 2006 (author's calculation).

### Technical notes:

Improving Reproductive Health (RH) outcomes, as outlined in the RHAP, includes addressing high fertility, reducing unmet demand for contraception, improving pregnancy outcomes, and reducing STIs.

The RHAP has identified 57 focus countries based on poor reproductive health outcomes, high maternal mortality, high fertility and weak health systems. Specifically, the RHAP identifies high priority countries as those where the MMR is higher than 220/100,000 live births and TFR is greater than 3.These countries are also a subgroup of the Countdown to 2015 countries. Details of the RHAP are available at *www.worldbank.org/population*.

The Gender-related Development Index is a composite index developed by the UNDP that measures human development in the same dimensions as the HDI while adjusting for gender inequality. Its coverage is limited to 157 countries and areas for which the HDI rank was recalculated

### Development partners support for reproductive health in Benin

**USAID:** Integrated 'family health' and HIV

**WHO:** Safer pregnancy; maternal and youth health; sexual, reproductive, and women's health focus

**UNICEF:** Maternal and child mortality reduction; girls' education

**UNFPA:** Reproductive health and rights

## Key Actions to Improve RH Outcomes

### Strengthen gender equality

- Support women and girls' economic and social empowerment. Increase school enrollment of girls. Strengthen employment prospects for girls and women. Educate and raise awareness on the impact of early marriage and child-bearing.
- Educate and empower women and girls to make reproductive health choices. Build on advocacy and community participation, and involve men in supporting women's health and wellbeing.

### Reducing high fertility

- Address the issue of opposition to use of contraception and promote the benefits of small family sizes. Increase family planning awareness and utilization through outreach campaigns and messages in the media. Enlist community leaders and women's groups.
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- Increase access to modern contraceptives for rural women and emphasize community-based distribution.
- Provide quality family planning services that include counseling and advice, focusing on women with no formal education, rural and poor populations. Highlight the effectiveness of modern contraceptive methods and properly educate women on the health risks and benefits of such methods.

### Reducing maternal morbidity and mortality

- Improve obstetric care in facilities and community and strengthen delivery of the package of emergency obstetric and neonatal care (EmONC) services as an integrated approach.
- Improve and expand EmONC training for health personnel and strengthen the referral system
- Improve institutional delivery through provider incentives and possibly, implement risk-pooling schemes. Provide vouchers to women in hard-to-reach areas for transport and/or to cover cost of delivery services.
- Strengthen the referral system by instituting emergency transport and training health personnel in appropriate referral procedures (referral protocols and recording of transfers).

### Reducing STIs/HIV/AIDS

- Integrate HIV/AIDS/STIs and family planning services in routine antenatal and postnatal care.
- Lower the incidence of new HIV infections by strengthening Behavior Change Communication (BCC) programs via mass media and community outreach to raise HIV/AIDS awareness and knowledge.

## References:


1. World Bank. *http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/AFRICAEXT/BENINEXTN/0,,menuPK:322649~pagePK:141132~piPK:141107~theSitePK:322639,00.html.*
2. World Bank, Benin Country Brief. *http://go.worldbank.org/OEOITK6RX0.*
3. World Bank. 2010. World Development Indicators. Washington DC.
4. World Bank, Engendering Development: Through Gender Equality in Rights, Resources, and Voice. 2001.
5. *http://hdr.undp.org/en/media/HDR_20072008_GDI.pdf*
6. Trends in Maternal Mortality: 1990–2008: Estimates developed by WHO, UNICEF, UNFPA, and the World Bank
7. DHS Final Report, Benin 2006, Institut National de la Statistique et de l'Analyse Économique (INSAE), and Macro International Inc.
8. WHO 2011. Making Pregnancy Safer: Adolescent Pregnancy. Geneva: WHO. *http://www.who.int/making_pregnancy_safer/topics/adolescent_pregnancy/en/index.html.*
9. Samuel Mills, Eduard Bos, and Emi Suzuki. Unmet need for contraception. Human Development Network, World Bank. *http://www.worldbank.org/hnppublications.*
10. Worldwide prevalence of anaemia 1993–2005: WHO global database on anaemia/Edited by Bruno de Benoist, Erin McLean, Ines Egli and Mary Cogswell. *http://whqlibdoc.who.int/publications/2008/9789241596657_eng.pdf.*
11. World Bank. 2010. Analytical report on health and poverty in Benin, #AAA51-BJ. Washington DC


### Correspondence Details


This profile was prepared by the World Bank (HDNHE, PRMGE, and AFTHE) and Management Science for Health (MSH). For more information contact, Samuel Mills, Tel: 202 473 9100, email: smills@worldbank.org. This report is available on the following website: *www.worldbank.org/population*.

## BENIN REPRODUCTIVE HEALTH ACTION PLAN INDICATORS

| Indicator | Year | Level | Indicator | Year | Level |
|---|---|---|---|---|---|
| Total fertility rate (births per woman ages 15–49) | 2006 | 5.7 | Population, total (million) | 2008 | 8.7 |
| Adolescent fertility rate (births per 1,000 women ages 15–19) | 2006 | 112 | Population growth (annual %) | 2008 | 3.2 |
| Contraceptive prevalence (% of married women ages 15–49) | 2006 | 17 | Population ages 0–14 (% of total) | 2008 | 43.2 |
| Unmet need for contraceptives (%) | 2006 | 29.9 | Population ages 15–64 (% of total) | 2008 | 53.6 |
| Median age at first birth (years) from DHS | - | - | Population ages 65 and above (% of total) | 2008 | 3.2 |
| Median age at marriage (years) | 2006 | 18.8 | Age dependency ratio (% of working-age population) | 2008 | 86.7 |
| Mean ideal number of children for all women | 2006 | 4.9 | Urban population (% of total) | 2008 | 41.2 |
| Antenatal care with health personnel (%) | 2006 | 88 | Mean size of households | 2006 | 5 |
| Births attended by skilled health personnel (%) | 2006 | 77.7 | GNI per capita, Atlas method (current US$) | 2008 | 700 |
| Proportion of pregnant women with hemoglobin <110 g/L | 2008 | 72.7 | GDP per capita (current US$) | 2008 | 771 |
| Maternal mortality ratio (maternal deaths/100,000 live births) | 1990 | 790 | GDP growth (annual %) | 2008 | 5.1 |
| Maternal mortality ratio (maternal deaths/100,000 live births) | 1995 | 690 | Population living below US$1.25 per day | 2003 | 47.3 |
| Maternal mortality ratio (maternal deaths/100,000 live births) | 2000 | 560 | Labor force participation rate, female (% of female population ages 15–64) | 2008 | 68.1 |
| Maternal mortality ratio (maternal deaths/100,000 live births) | 2005 | 460 | Literacy rate, adult female (% of females ages 15 and above) | 2008 | 28.1 |
| Maternal mortality ratio (maternal deaths/100,000 live births) | 2008 | 410 | Total enrollment, primary (% net) | 2008 | 92.8 |
| Maternal mortality ratio (maternal deaths/100,000 live births) target | 2015 | 200 | Ratio of female to male primary enrollment (%) | 2008 | 86.6 |
| Infant mortality rate (per 1,000 live births) | 2008 | 76 | Ratio of female to male secondary enrollment (%) | 2005 | 56.7 |
| Newborns protected against tetanus (%) | 2008 | 92 | Gender Development Index (GDI) | 2008 | 145 |
| DPT3 immunization coverage (% by age 1) | 2006 | 64.5 | Health expenditure, total (% of GDP) | 2007 | 4.8 |
| Pregnant women living with HIV who received antiretroviral drugs (%) | 2005 | 16.6 | Health expenditure, public (% of GDP) | 2007 | 2.4 |
| Prevalence of HIV, total (% of population ages 15–49) | 2007 | 1.2 | Health expenditure per capita (current US$) | 2007 | 31.9 |
| Female adults with HIV (% of population ages 15+ with HIV) | 2007 | 62.7 | Physicians (per 1,000 population) | 2008 | 0.059 |
| Prevalence of HIV, female (% ages 15–24) | 2007 | 0.9 | Nurses and midwives (per 1,000 population) | 2008 | 0.771 |

| Indicator | Survey | Year | Poorest | Second | Middle | Fourth | Richest | Total | Poorest-Richest Difference | Poorest/Richest Ratio |
|---|---|---|---|---|---|---|---|---|---|---|
| Total fertility rate | DHS | 2006 | 7.0 | 6.6 | 6.2 | 5.3 | 4.2 | 5.7 | 2.8 | 1.7 |
| Current use of contraception (Modern method) | DHS | 2006 | 2.4 | 3.7 | 5.0 | 6.7 | 13.2 | 6.1 | –10.8 | 0.2 |
| Current use of contraception (Any method) | DHS | 2006 | 7.7 | 11.5 | 13.6 | 19 | 33.6 | 17.0 | –25.9 | 0.2 |
| Unmet need for family planning (Total) | DHS | 2006 | 30.3 | 30.1 | 31.2 | 31.3 | 26.5 | 29.9 | 3.8 | 1.1 |
| Births attended by skilled health personnel (percent) | DHS | 2006 | 57.6 | 71.7 | 80.6 | 91.4 | 97.5 | 77.7 | –39.9 | 0.6 |

## National policies and strategies that have influenced reproductive health

**National Policy and Norms Document for HIV testing:** *UNAIDS/WHO supported regulations for improved HIV testing coverage and quality, and reduced stigma*

**1996 Essential Services Package:** *Defined essential services of the MoH for children's health, women's health, adolescent health, and men's health*

**1999 Policy and Standards in Family Health:** *Strategy for development of the health sector specific to reproductive health*

**2006 National strategy for reducing maternal and neonatal mortality**