Obstetric fistula: the international response

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The advent of modern obstetric care has led to the eradication of obstetric fistula in nearly every industrialised country. However, in the developing world obstetric fistula continues to cause untold pain and suffering in millions of women. The very existence of this condition is the result of gross societal and institutional neglect of women that is, by any standard, an issue of rights and equity.

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A patient recovering at the Addis Ababa Fistula Hospital, Ethiopia

In the developing world, obstetric fistula is almost always the result of obstructed labour. During prolonged obstructed labour the soft tissues of the pelvis are compressed between the descending baby's head and the mother's pelvic bone. The lack of blood flow to these tissues leads to necrosis and ultimately a hole forming between the mother's vagina and bladder (vesicovaginal) or vagina and rectum (rectovaginal), or both, that leaves her with urinary or faecal incontinence, or both. Early intervention to relieve obstructed labour will restore perfusion to these tissues and, in most cases, will prevent fistula. The results of fistula are devastating. In nearly every case the baby is stillborn. Women and girls with fistula are unable to stay dry. They smell of urine or faeces and are shunned by the community and, at times, even by their own husbands and families. They remain hidden, shamed, and forgotten.

Current, reliable data on the prevalence of obstetric fistula are scarce. In 1989, WHO estimated that more than 2 million girls and women around the world had this condition, with an additional 50 000 to 100 000 new cases occurring every year.[1,2] These figures were based on women seeking treatment, and are therefore likely to be gross underestimates. Since 1989, most research on the prevalence and incidence of fistula has been small scale and done mostly by practitioners and the few non-governmental organisations (NGOs) working with fistula patients. The validity of these studies is very variable, but all indicate that the number of women affected is alarmingly high—in some countries up to 350 per 100 000 livebirths, with a backlog of unrepaired cases nearing 1 million in northern Nigeria alone.[3,4]

The lack of accurate information has two causes: neglect of the issue, and practical difficulties. Women with fistula are most often from remote rural communities and may never present for treatment. Furthermore, many women present with stress incontinence after delivery; thus, to differentiate the conditions, any accurate study of fistula should include a physical examination, which can be costly, time-consuming, and culturally sensitive. A global, population-based survey of obstetric fistula is needed but would be costly as well as ethically difficult since curative services are not currently available for all affected women.

Poverty is the main risk factor for obstructed labour and fistula, compounded by social norms such as early marriage before physiological development is complete, and malnutrition and general poor health. Additionally, in many cases, families do not have enough money to pay for transport to reach medical help.

Girls who have educational and vocational opportunities delay childbearing, thereby reducing their risk of fistula.[5,6] Fistula prevention should be incorporated into programmes designed to provide girls with opportunities enabling them to delay marriage. Raising awareness of the condition is also important for prevention. Policymakers in the area of safe motherhood often underestimate the toll of fistula—both the numbers of cases and the depth of suffering it causes, and education might enable them to have a larger role in prevention. Community leaders can also be key in prevention efforts if willing to promote a later age of marriage and childbirth and support schemes transporting women to health centres.

Finally, fistula prevention programmes must include provision of emergency obstetric care, and more specifically, of swift and safe caesarean sections for women in obstructed labour. To reduce maternal mortality and morbidity it is recommended that at least 5% of deliveries are done by caesarean section.[7] An analysis of data from demographic health surveys in sub-Saharan Africa showed that caesarean section rates were below 5% in seven of the

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Tshai stands outside the Indebeguna Clinic, Tigray Province, Ethiopia
The clinic provides only basic health care and no emergency obstetric care. Tigray Province is where many of the Addis Ababa Fistula Hospital patients come from.

eight countries studied and below 2% in four.[8] Symphysiotomy can also be done to relieve obstructed labour. It may be worth supporting this procedure as a means of fistula prevention in areas where caesarean section is not readily available.

Combining fistula prevention with support for safe motherhood programmes will focus resources and services. Because the prevention of fistula includes access to family planning information and services, as well as access to quality maternal care, the incidence and severity of fistula can be used as a gauge of the overall effectiveness of maternal health programmes.

Prevention efforts, however successful, will not alleviate the suffering of women who already live with fistula. Many women live with fistula for decades, either unaware that a cure is possible, or unable to access services. Reconstructive surgery is successful in 88–93% of first-time cases and costs about US$350.[9] Unfortunately, this amount is out of the reach of many families. Even when women can raise the funds, few facilities provide repairs. The need to improve the quality and availability of reconstructive services is huge and requires organisation, funding, and concrete action plans.

Women who have been cured are able to return to their families and resume full and productive lives. They can serve as ambassadors for their communities by raising awareness of the dangers of obstructed labour and early pregnancy. Fistula survivors can also provide information about their experiences leading up to and living with fistula. Every woman with a fistula resulting from obstructed labour can be considered a "near miss" for maternal mortality; thus interviews with fistula survivors are an important adjunct for the verbal autopsy and near miss techniques used to gather qualitative data from the families and communities of women who have died or nearly died in childbirth.

In 2002, UNFPA launched a global campaign to end fistula in partnership with multilateral agencies, NGOs, social scientists, and a growing network of health professionals. The campaign has several aspects: increasing the capacity for prevention, treatment, and rehabilitation at existing facilities; establishing fistula centres in every country in which they are needed; and helping community development agencies to address prevention through education and promoting later marriage and childbearing. In 2002, campaign partners (EngenderHealth, Women's Dignity Project, and African Medical Research Foundation) catalogued existing services and assessed further needs in 12 African countries: public and private hospitals were visited; administrators, professional staff, and fistula patients were interviewed; and meetings were held with ministries of health and local policymakers. There are plans to extend these assessments to other African countries and other affected regions such as Asia and the middle east.

Individual agencies are doing groundbreaking research. For example, in Tanzania, a survey of fistula service providers by the Women's Dignity Project catalogued the number and frequency of repairs done at facilities throughout the country. The responses were used to create a comprehensive map of available services. The research led to the development of a scheme with a three-level referral system ranging from the provision of early obstetric care and the use of post-partum bladder catheterisation to a medical centre in which fistula repairs are done by well trained surgeons.[10]

Obstetric fistula is preventable and treatable. Individuals and organisations are mobilising resources and bringing new attention and energy to the fight against fistula, but there remains much to be done. Eradication has already been achieved in many resource-poor countries, providing hope that this can be achieved everywhere. The eradication of fistula will alleviate the suffering of millions of women, and will be a tremendous step in making motherhood safer for all women.

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