EDITORIAL

Reducing the scourge of obstetric fistulae in sub-Saharan Africa: A call for a global repair initiative

Friday Okonofua[1]

Editor, African Journal of Reproductive Health and Provost, College of Medical Sciences, University of Benin, Benin City, Nigeria[1]

Existing data indicate that a substantial proportion of the nearly 500,000 women who die globally during childbirth occur in sub-Saharan Africa. However, it is well known that maternal mortality figures are a mere fraction of the actual burden of maternal morbidity and mortality in Africa. For each case of maternal death, nearly 10 women suffer severe morbidity associated with damage to the reproductive tracts of women and long term suffering.

The most dramatic of these is obstetric fistulae, also called vesico-vaginal fistula (VVF), characterized by the prolonged and continuous leakage of urine through the vagina. The condition is one of the major complications of prolonged obstructed labour, predominantly occurring in low income countries, where women have persistently had poor access to skilled birth attendants during labor.

TheWorld Health Organization estimates that about 2 million women currently live with obstetric fistulas throughout the developing world, and that another 50,000 to 100,000 new cases occur each year[1]. The majority of these cases occur in sub-Saharan African countries due to bad obstetric practices and the adverse socioeconomic and cultural context under which women become pregnant and give birth. The most severely affected countries are Nigeria, Ethiopia, Tanzania and Kenya, where significant proportion of women may labour for days without the help of a skilled birth attendant. The resultant pressure of the fetal head compressing the bladder and the vagina behind the pelvic bone causes prolonged loss of blood supply, tissue death, sloughing and the formation of permanent passage between the bladder and the vagina. In some cases, a passage may also be created between the rectum and vagina resulting in a recto-vaginal fistula and the permanent passage of feces through the vagina. The UNFPA estimates that nearly 800,000 cases of obstetric fistulae currently exist in Nigeria alone[2], principally in the northern part of the country, where long-standing traditional and religious practices have contributed significantly to escalating the problem.

Apart from the inconvenience of continuous leakage of urine from the vagina that affected women suffer, the disease is associated with several social and psychological consequences for women. These include stigmatization, abandonment, social ostracization, and the impoverishment of women. In recognition of these, several international conferences including the ICPD and the Fourth World Conference on Women have identified the prevention, treatment and rehabilitation of women affected by obstetric fistulas as an important human rights and public health goal, which must be addressed in efforts to improve the reproductive health and social status of women in developing countries.

Despite the severe nature of the problem in contributing to the poor state of women's reproductive health and rights in sub-Saharan Africa, it is surprising that very little is currently being done at the international and national levels to address the problem. The huge international outcry that initially heralded the problem has now abated and there is evidence that there is now waning of enthusiasm to address the problem in a realistic and sustainable manner.

To date, three approaches for addressing the problem of obstetric fistulas have been advocated. These include (1) the postponement of marriage and sexual relations among very young girls; (2) increasing women's access to adequate medical care during labour and delivery; and (3) tertiary prevention through the repair of existing fistulas. We believe that primary prevention of obstetric fistulas through postponement of marriage and increasing women's access to skilled birth attendants within countries should continue to be the major emphasis. The components of primary prevention includes promoting women's education and economic empowerment, eliminating cultural and traditional norms that encourage early marriage, promoting best birth practices and encouraging

broader aspects of community development. Interventions to address these issues are currently being undertaken in many parts of Africa. However, the efforts will take time to materialise, and will likely take several years of multi-sectorial social and economic reforms and development in these countries for any measurable changes to take place. Thus, while primary prevention efforts are being consolidated, there is a need to put in place strategies for reducing the number of women emboldened by the disease through repair of existing fistulas.

A strategy focused on repairs of fistulas is important for two additional reasons: (1) it will reduce social misconceptions that perceives fistulas as due to women's misdeeds, a belief that presently hinders prevention efforts in countries with high rates of fistulas; and (2) it will provide an opportunity for the full rehabilitation of affected women, an important intervention needed to promote the reproductive rights, individual dignity and social status of women. The information and skills necessary to repair obstetric fistulas are available, but ought to be more accessible and affordable to women suffering from the disease.

The major barriers to repair of existing obstetric fistulae in many parts of Africa include the lack of facilities and human resource in many of the affected countries, and the poor health seeking behaviour of women affected by the disease. Only few health institutions have the capacity to undertake repair of fistulae in many parts of Africa. The repair of obstetric fistulae is the responsibility of obstetricians and gynaeco-logists who often undertake the repair through the vagina route and urologists who undertake the more difficult repairs through the vagina or abdominal route. In addition to the relative lack of obstetricians and gynaecologists and urologists in many African countries, only a few existing specialists have experience in undertaking fistula repairs. We estimate that less than 10 percent of women affected by obstetric fistulae have ready access to a health institution with available personnel and facilities to undertake repair in many parts of Africa. Even when facilities exist, affected women are often poor and illiterate and may not have the necessary information and resources (as a result of high costs of repair) to access available services.

Thus, as part of efforts to address this problem, fistula repair hospitals, with subsidized services have been established in countries such as Nigeria and Ethiopia[3,4], but these have failed to address the problem as these hospitals have the capacity to undertake only a few repairs compared to the large number of existing caseloads of obstetric fistulae. Furthermore, these specialized hospitals have mainly been set up by expatriates working to alleviate the problem, with little efforts made by the local health community to integrate the repair and rehabilitation of persons affected by obstetric fistulae into their existing health promotion plans. Indeed, there is currently lack of well trained indigenous human resource to undertake fistulae repairs in many African countries with large number of obstetric fistulae.

Thus, we believe that African countries should endeavour to include the repair and rehabilitation of women affected by obstetric fistulae into their health budgets and to take realistic steps to achieve this part of the Millennium Development Goals in their countries. Additionally, this is an area where major international effort can be concentrated to achieve a major health outcome for a large number of deprived populations within a conceivable period of time. We believe that a major international initiative to repair all obstetric fistulae within ten years can be undertaken along the lines of such major health promotion efforts as the elimination of polio, tuberculosis, HIV/AIDS and malaria. The total repair of all obstetric fistulae throughout the world is an initiative that is achievable within a reasonable period of time, while steps are intensified to prevent the occurrence of new cases. Indeed, the repair of existing cases will provide impetus for the prevention of new cases of obstetric fistulae and also enhance the promotion of other aspects of women's health. This can be achieved through intense national and international advocacy, public health education in affected countries, capacity building of health professionals, certification and improvement of health institu-tions, provision of cost subsidies and strategies put in place to re-habilitate affected women.

Apart from the affirmations at the ICPD and the Fourth World Conference on Women in Beijing, China, the repair and rehabilitation of women affected by obstetric fistulae is a right guaranteed for women under various international human rights treaties, including the African Charter on Human and Peoples' Rights[5]. Consequently, the international community can no longer afford to be complacent and must take steps to protect these rights.

The World Health Organization, the UNFPA and international professional associations such as the International Federation of Gynaecologists and Obstetricians (FIGO) and the International

Confederation of Nurses and Midwives (ICM) should take a lead in mobilizing the rest of the world to support efforts to repair all existing obstetric fistulae and rehabilitating affected women within a reasonable time frame. A major fistula repair initiative focusing on countries with the highest prevalence rates will be one way to promote women's reproductive health and redress social iniquities in developing countries in the next decade.

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