

Obstetric Fistula – An Unceasing Scourge in the Developing World

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Commentary

Obstetric fistula is a devastating problem known to mankind from time immemorial [1]. It is an abnormal opening into the vagina leading to continuous involuntary leakage of urine and/or faeces following childbirth. The commonest type is vesicovaginal fistula. Other variants include rectovaginal fistula, urethrovaginal fistula, ureterovaginal fistula and vesicouterine fistula. It is a complication of childbirth seen among reproductive-age women who lack access to quality maternity care. It is characterized by urinary and/or faecal incontinence and the resultant shame and social exclusion [2-4].

While obstetric fistula has virtually disappeared from the developed world, it has remained unremitting in the developing world due to poverty, illiteracy, noxious cultural practices and fragile health systems that have shown minimal improvement over time [1,3,4]. As a result, untold populations of women in the developing world have continued to endure the tremendous hardship associated with the condition [3,4].

Obstetric fistula is prevalent in resource-poor countries of the world notably in Sub-Saharan African and South Asia [1,4,5]. It is particularly common in countries like Ethiopia, Nigeria, Sudan, Niger, Chad, Ghana, Uganda and Bangladesh [6]. Globally, an estimated 50 000 to 100 000 women develop obstetric fistula every year. Over 2 million young women are said to be living with untreated obstetric fistula in different parts of Asia and Sub-Saharan Africa [7]. Nigeria, for example, has 400 000 to 800 000 women affected, with about 12 000 new cases every year, thereby constituting about 40% of the global burden of the disease [8]. Although the global prevalence is said to be about 1-2 per 1000 deliveries, in South-East Nigeria, a prevalence as high as 43.6 per 1000 deliveries has been reported [9].

Prolonged obstructed labour is responsible for the vast majority (over 80%) of cases of obstetric fistula [6,9]. It is usually a result of interplay of myriads of socio-cultural and political factors. These include extreme poverty, malnutrition, illiteracy, early marriage, lack of antenatal care, lack of access to facilities with skilled birth attendants, poor funding of health systems, and cultural practices such as female genital mutilation, aversion to operative delivery and non-participation of women in decision making [9-12]. Less commonly, obstetric fistula may also result from surgical procedures such as caesarean section [13,14].

Due to industrialization, improved economic and technological development, and improved healthcare delivery, obstetric fistula is now unheard-of in the developed world. It has however remained a scourge in the developing nations with their characteristic poor gross domestic product (GDP), poor gross national product (GNP) and low per capita income. The perpetuation of fistula despite massive sensitization by successive governments as well as the activities of development partners is of grave concern. More worrisome however, is the occurrence of huge numbers of fresh cases due lack of access to quality maternity care, increasing patronage of quacks occasioned by

dwindling economic fortunes and wanton destruction of existing healthcare facilities by activities of insurgents in some of these countries.

Eliminating the problem of obstetric fistula in the developing world requires a two-pronged approach – preventing new cases and clearing the backlog of fistula cases. With extreme poverty, illiteracy and underdevelopment as the root causes, there is an urgent need for the government of these countries to muster sufficient political will to combat this monster. This entails industrialization, education, improvement in human capital development, increased budgetary allocation to healthcare and strengthening of the healthcare system to provide emergency obstetric care.

Policies that enhance access of rural women to quality healthcare should be encouraged. For instance, access to care could be improved by introducing the care manager partnership model. This entails engagement of specially-trained care managers who will help pregnant women interface with the health facility/care givers. They will visit, monitor and assist the women to make health-promoting decisions as well as improve compliance with prescriptions and instructions. They also help with patient information, education and motivation. This partnership has been shown to reduce the barriers that prevent utilization of health facilities, resulting in good clinical outcomes and better disease management [15].

Clearing the backlog of obstetric fistula cases is a herculean task. In some developing countries, the huge burden of fistula cases notwithstanding, there is scarcity of fistula centres as well as fistula surgeons. In Nigeria, with a vast population of obstetric fistula patients, some of whom have lived with the problem for decades, there are less than twenty centres offering surgical care to less than 5,000 fistula patients per year. At this rate, experts have projected that it may take about 100 years to clear the backlog of cases without considering the fresh ones [16]. There is thus the need to establish more specialized centres in these countries. There is also the need to train a huge number of fistula surgeons to facilitate the eradication of the backlog of cases.

Given the fact that little progress has been made despite the activities of development partners and non-governmental organizations that dot the length and breadth of many of the developing countries, the governments of these countries need to synchronize the activities of these organizations. All these measures, if adopted, will help eradicate the scourge of obstetric fistula, bearing in mind that eradicating obstetric fistula in developing countries is tantamount to eradicating it in the world.

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