Addressing Obstetric Fistulas

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Defining Obstetric Fistulas

The Continuum of Care for Obstetric Fistulas

UNFPA Objectives for Obstetric Fistulas

Cost and Challenges of Addressing Obstetric Fistulas

Overview

When people first learn about obstetric fistulas and their disastrous effects, the usual reaction is to reject hearing more—the subject is just too unpleasant. Rejection is exactly what happens to fistulas' survivors.

An obstetric fistula is an injury of a woman's birth canal that most often occurs when a very young girl is pregnant and experiences a long and obstructed labor. The baby usually dies. The mother, if she survives, suffers tissue damage to the birth canal that becomes an opening between the vagina and the bladder or rectum. This creates a constant leakage of urine or feces, sometimes both.

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The results are devastating. The girl is unable to stay dry. Her genital area ulcerates from the wetness and she suffers from frequent infection. The smell of urine or feces is constant and humiliating. Rather than being comforted as a survivor, the girl may be considered unclean and ostracized from her family and community, even blamed for her own condition. Often she is abandoned by her husband. On top of this, the girl grieving for her stillborn child may also suffer pain or crippling from nerve damage to her legs.

Fistulas afflict at least an estimated 2 million females, nearly all of them young, very poor and living in the developing world. These are places where malnutrition and stunted growth make obstructed labor more likely, or where the culture or political strife leads to pregnancies among very young girls. In many of these places, access to medical care is limited or mistrusted, and Caesarean delivery is largely unavailable.

- The World Health Organization estimates that some 2 million females are living with obstetric fistulas, and that another 50,000 to 100,000 new cases occur yearly. [1]

- Estimates come from actual cases of women seeking treatment in hospitals and clinics and are likely to be grossly low. Reliable data are nonexistent.

- The shame associated with fistulas means uncounted numbers of women live with the probelm for years, isolated and unaware that a cure is possible.

Fortunately, fistulas can usually be corrected surgically, and these girls can resume a normal life once they are repaired.

The best solution, however, is threefold:

- Postpone marriage and sexual relations for very young girls;

- Provide access to adequate medical care for all pregnant women; and

- Repair physical damage through medical intervention and the emotional damage through counseling.

Fistulas were once widespread in Europe and America and other wealthier areas, but were all but eradicated by modern medical care after the early 1900s. They are almost completely preventable.

—April 2002

1. Arrowsmith, S.; Hamlin, E.C.; and Wall, L.L.; "Obstructed Labor Injury Complex: Obstetric Fistula Formation and the Multifaceted Morbidity of Maternal Birth Trauma in the Developing World," *CME Review Article,* Obstetrical and Gynecological Survey, Vol. 51 #9, 1996
2. World Health Organization Division of Family Health, "The Prevention and Treatment of Obstetric Fistulae: Report of a Technical Working Group," WHO, Geneva, April 17-21, 1989, p. 6
3. Tahzib, Farhang, "Epidemiological determinants of vesicovaginal fistulas," *British Journal of Obstetrics and Gynaecology,* Vol. 90, May 1983, pp. 387-391
4. Olorunyomi, Ladi, "Vesico-Vaginal Fistula—the Scourge," *Newsletter,* Women's Global Network for Reproductive Rights, #60-9, 1997
5. Lawson, John, "Vaginal fistulae," letter in *Journal of the Royal Society of Medicine,* Vol. 85, May 1992, pp. 254-256

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Defining Obstetric Fistulas

Early or closely spaced childbearing may have severe consequences for women. Many die in labor that is prolonged or obstructed, and the survivors may have permanent disabilities. One of the worst results is obstetric fistulas and the nerve damage known as "foot-drop." The physical, social and emotional consequences are devastating: constant leakage of urine or feces or both, infection, humiliation, and social ostracism.

Defining obstetric fistulas:

An obstetric fistula is a hole that develops between a woman's vagina and her bladder or rectum, or both, usually as a result of trauma during childbirth. If a woman's baby will not fit through her birth canal because her pelvis is too small or the baby is too big or badly positioned, the labor is said to be obstructed.

The baby's head becomes wedged in the mother's pelvis, cutting off the blood supply to the soft tissues of her bladder, rectum and vagina.Where there is inadequate obstetric care, a woman may be in obstructed labor for three or four days without relief. The baby usually dies. If the mother survives, her injured pelvic tissue soon rots away, creating a fistula.

Fistulas may also result from ritual genital cutting, unsafe abortion attempts, pelvic fractures or other injury.

Consequences of obstetric fistulas:

- Women with bladder (vesico-vaginal) fistulas have no control over their urine, and those with rectal (recto-vaginal) fistulas have no control over their bowel movements.
- The women suffer from discomfort and humiliation of constant wetness that leaves them with genital ulcerations, frequent infections and a terrible odor.
- Rupture or scarring of their uteruses may have left them infertile.
- Affected women are often blamed for their condition, which may be confused with venereal disease. They are shamed, ostracized, divorced, abandoned, isolated and left without support. Many women are forced to become beggars.

- Women who formerly prepared or sold food for a living usually can no longer do so, as they and their possessions are regarded as unclean. They may be excluded from religious practices and barred from public transportation.

- As most of these women's babies died from the obstructed labor, and many suffer infertility afterward, they may be further isolated in societies where childlessness is unacceptable and social support systems require kinship groups.

Social barriers:

While the proximate causes of fistulas are physical injuries, the larger causes are social: poverty, lack of education, childbearing at too early an age and lack of medical care.

- In many rural areas, girls are married off just after they experience their first menstrual flow—between 10 and 15 years of age.

- Traditional practices that postponed such girls' cohabitation and sexual relations with their husbands have disintegrated with modernization. [1]

- Western medicine and medical facilities may not be trusted, or may be used only as a desperate last resort when damage is already far advanced.

A 1983 study in Nigeria of 1,443 fistula surgery patients found that 84 percent of the lesions resulted from prolonged obstructed labor, and 13 percent from a ritual or traditional *gishiri* cut of the genitalia. The rest were from surgical trauma, infections including measles and diphtheria, and other injuries.[2]

The same study found that 55 percent of the fistula sufferers were under 19 years of age, and a third were under 16. Only 6 percent of them had undergone child-birth at a hospital; the rest delivered at home or at a poorly equipped clinic. The 81 cases of Caesarean deliveries that were noted came after prolonged labor when bladder tissue damage had likely occurred already.[2]

Preventing obstetric fistulas:

- Postponing the age of marriage and childbirth until the woman's body is mature is key, along with family planning to space children to allow recovery time.

- Measures to alleviate poverty and malnutrition can reduce the physical frailties that contribute to obstructed labor.

- Universal access to basic reproductive health care allows screening and referral to skilled care for pregnant women likely to suffer obstructed labor.

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1. Olorunyomi, Ladi, "Vesico-Vaginal Fistula—the Scourge," *Newsletter,* Women's Global Network for Reproductive Rights, #60-9, 1997
2. Tahzib, Farhang, "Epidemiological Determinants of vesicovaginal fistulas," *British Journal of Obstetrics and Gynaecology,* Vol. 90, May 1983, pp. 387-391

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The Continuum of Care for Obstetric Fistuals

"For every woman who dies, 15 more are left with some serious problems. Often they can't have any more children, which has tremendous social consequences. In some cases they are abandoned by their family."

—Memorial University midwife Kay Matthews
working in the Akwa Ibom region of southeast Nigeria

Obstetric fistulas are almost entirely preventable. The continuum of care requires a three-part approach. It is critical to prevent marriage and childbearing by very young girls; provide access to adequate medical care for all pregnant women; and repair the fistula and its effects on those who suffer from it.

These measures have far-reaching implications, involving cultural change, investment of resources and responsible policy decisions and new patterns of behavior by all concerned.

- Often legal and social change is required to improve the status of women and give young girls better nutrition, access to medical care, primary education and other options for life besides childbearing, as well as the option of postponing marriage—and thus pregnancy—until they are fully grown.

- Men's involvement is crucial in achieving change. Some cultures believe difficult labor indicates the wife has been unfaithful. Men often decide when and whether to seek medical care, and they usually provide or arrange transport to it.

Providing access to medical care:

- Experience shows fistulas result from three classic delays that must be addressed: a delay in the decision to seek medical attention; a delay in reaching a health care facility; and a delay in receiving care once present at the facility.

- Investment in primary and reproductive health care systems, including transportation, should be a priority. Training for midwives and traditional birth attendants should stress timely referral of likely obstructed labor pregnancies to skilled care centers.

- Reproductive health care involves access to family planning, skilled attention during childbirth and referral and transport to skilled obstetric care for women at risk of a difficult delivery.

Treatment:

- In areas where many women await treatment, fistula centers should be created, perhaps attached to major regional or teaching hospitals but with their own operating theaters, along with hostels to house the women before and after surgery.

- Women with obstetric fistulas, often in hiding and unaware that a cure is possible, must be located, identified and persuaded to come in for treatment and counseling.

- The surgery is delicate and technically difficult. A specially trained surgeon and support staff, and access to an operating facility are required.

- Attentive post-operative care involving a catheter or rectal bypass is critical for 10-14 days while the surgery heals, in order to prevent infection.

- Success rates for primary surgical repair range from 88 to 93 percent, decreasing with successive attempts.

Education is also an important part of the treatment.

- Fistula survivors who have been shunned and isolated typically suffer from intense feelings of shame, self-loathing and depression. They may be suicidal and blame themselves for their situation.

- Education and counseling can restore self-esteem and bring relief, and can repair the emotional and psychological damage.

- Social rehabilitation programs can help women reintegrate themselves into their communities following surgery. Studies show that 90 percent return successfully. [1]

Taking action:

The Hamlin Fistula Hospital in Addis Ababa, Ethiopia, has treated more than 20,000 women since it opened in the 1970s and reports a 93 percent success rate in repairing urinary-tract fistulas.[2]

Hospital capacity is 1,200 women per year, far less than demand, which continues to increase. Satellite centers are planned elsewhere in Ethiopia. Former patients have become nurses, hospital staff, and outreach workers to other fistula sufferers throughout Ethiopia. One has even become a surgeon. The Ethiopian government has given a land tract for another center, and the hospital gives local doctors two-month training courses to raise capacity. But funds are lacking to finance an expansion of facilities or training.

The Family Life Centre in Nigeria has been struggling with a nationwide deterioration of basic health services in its attempt to help some of the country's estimated 1 million women with unrepaired fistulas. The Nigerian National Foundation on Vesico-Vaginal Fistulas works to raise public awareness of the problem, promote an end to child marriages, provide midwife services, and secure support for the Centre.

In Mwanza, Tanzania, the Bugando Medical Centre, which serves an area of eight million people and is the country's second largest referral hospital, set up a special clinic for fistula treatment. With one radio announcement, the clinic attracted scores of patients and treated 150 over two years. [3] Educational outreach included workshops for doctors, nurses and midwives; a pocket-sized booklet story of a young girl with a fistula; information sheets distributed nationwide; and wall murals to raise awareness of the problem. Of 50 patients studied, 20 reported no cash income whatever and the rest indicated low-income status. Their immediate cure rate was 80 percent. [3]

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1.Tahzib, Farhang, "Epidemiological determinants of vesicovaginal fistulas," *British Journal of Obstetrics and Gynaecology,* Vol. 90, May 1983, pp. 387-391

2. Hamlin Fistula Relief and Aid Fund Website, http://www.geocities.com/fistulatrust/hospital.html.

3. Bangser, M., Gumodoka, B., and Berfege, Z., "A Comprehensive Approach to Vesico-Vaginal Fistula: A Project in Mwanza, Tanzania," in Berer, M., and Ravindran, S., *Safe Motherhood Initiatives: Critical Issues,* Reproductive Health Matters, United Kingdom, 19991.Footnotes

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UNFPA's Objectives for Obstetric Fistulas

UNFPA's 30 years of experience in providing education and services for reproductive health has long included advocacy for the changes in law and social policy that are crucial in preventing obstetric fistulas. The action programmes of the 1994 International Conference on Population and Development and the 1995 Fourth World Conference on Women parallel UNFPA's mandate in urging sexual and reproductive health and rights for women. These include education, family planning, safe motherhood and options for young girls beyond childbearing.

More recently, UNFPA joined the International Federation of Obstetrics and Gynecology (FIGO) and Columbia University's Averting Maternal Death and Disability programme (AMDD) to offer support to survivors of fistulas and to prevent further cases. Their working group seeks to mobilize the international community on the need for urgent action, and to create a Fistula Fund to support treatment and prevention work in the multiple locations where it is most needed.

UNFPA's role:

- UNFPA typically supports projects to provide young girls and women with family planning information and services, antenatal care and education about nutrition and personal health, and skilled attendance at birth, with referral and transport to expert medical facilities for complications of delivery such as obstructed labor.

- Obstetric fistulas are one consequence of the poverty and lack of rights and education that afflict millions of young girls and women worldwide. Where early marriage is discouraged, girls are educated about their bodies and their rights, and where skilled medical care is provided at childbirth, obstetric fistulas are all but unknown.

"My greatest job is to persuade them that they are not bad people and that what happened to them occurred because they are poor, they have no medical services, and they could not get to hospital in time for a Caesarian section."

—Dr. Ann Ward
obstetrician/gynecologist , southeast Nigeria

The Working Group on Fistulas:

UNFPA, AMDD and FIGO have each pledged US $750,000 over three years to begin an international campaign against obstetric fistulas. These funds will support advocacy and public outreach and educators as well as direct action at existing fistula repair centers. UNFPA, in partnership with FIGO and AMDD, will work to prevent new cases of obstetric fistulas and provide services for affected women.

- The Working Group held its first annual meeting in July 2001 to assess current research on fistulas, survey the geographical reach of the problem and plan appropriate and workable responses.
- Starting with UNFPA and FIGO contributions, the group is laying the groundwork for a Fistula Fund to support existing treatment centers and spark new ones, especially in sub-Saharan Africa where the need is greatest.
- A baseline study of need and existing treatment capacity is underway in eight African countries to identify locations where support would be most effective. The study is looking at existing smaller treatment centers, training sites, and new areas for expansion.

Strategies for change:

The Working Group will target the national and international media and decision-makers to win attention and concern for the problem of obstetric fistula.

- UNFPA has created a video news release on the issue and collected others to aid journalists and others in understanding.
- Field trips to UNFPA-supported reproductive health centers are in the planning stages.
- The Working Group will reach out to the medical community to raise its awareness of obstetric fistula and to support training for surgeons and nurses in treating it and caring for its survivors.

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Costs and Challenges of Addressing Obstetric Fistulas

The full extent of the problem of obstetric fistulas has never been mapped. Rescuing fistula sufferers from their hidden world of shame and pain requires compassionate outreach and large-scale investment that so far has not been forthcoming. Yet fistula repair is inexpensive compared to the cost of addressing many less devastating ailments.

In sub-Saharan Africa where the problem is worst, about US $2,500 will train a surgeon to perform fistula repair. US $350 to $400 will finance one operation and the necessary 10-14 days of careful post-operative care. These sums are far beyond the capacity of most fistula survivors to pay.

But funding for surgical repair, hard as it is, is the easy part. Obstetric fistulas result chiefly from problems of culture and poverty that challenge the whole planet.

Eradicating fistulas requires many of the same long-term difficult social actions required to combat poverty, promote development and slow population growth. These include universal access to education and reproductive health care for all, especially women and equal access for women credit.

The extent of the problem is undocumented.

- Developing world medical facilities that begin to offer fistula repair commonly report a surprising and growing stream of afflicted women requesting help as word of mouth spreads the news that it is available, often having to turn applicants away.

- Delays in seeking timely obstetric care are a major cause of fistulas, but they are common, often because poor families fear they will be unable to pay the medical fees. Centers that offer free care report major increases in demand.

- The typical fistula patient who arrives at the Addis Ababa Fistula Hospital in Ethiopia for care says she has suffered from her condition for at least five years. [1]

The financial gap:

- More is needed for outreach to victims and their families and for broad-based education to avert the shaming that victims suffer.

"The point to be made here is that it's the greatest cause of death of women in the childbearing age group, it is more significant than AIDS or tuberculosis, and there is no male equivalent. Billions are spent on birth control programs but very little on emergency obstetrics care, so that while fertility has come down, maternal mortality has remained stable or is in fact going up."

—Dr. Rob Walley, MaterCare International

- Planners of a proposed fistula repair center in Ghana estimated construction and start-up costs at US $2 million, providing a benchmark figure for future reference. Most centers, however, do not start from scratch but within hospitals or clinics.

- The Hamlin Fistula Hospital in Addis Ababa, Ethiopia, is able to meet its current operating expenses but cannot expand on current funds. Expansion to meet demand will require US $100,000 per year in new funding in addition to start-up costs. Current annual operating costs are approximately US $400,000 to treat 1,200 women per year. The approximate cost of surgery is $350 per case, which includes the 10-14 days of skilled post-operative care necessary to prevent infection.

- The Family Life Center in Nigeria has been overwhelmed by demand from the country's estimated 1 million women with unrepaired fistulas (also see Continuum of Care Fact Sheet).

- An efficient way to build capacity is to renovate existing operating theaters and wards, create free or low-cost housing for surgeons and nurses, and hostels for trainees and for patients awaiting or recovering from treatment.

- Training programs should focus on and support local physicians and support staff in order to provide skilled, constant and reliable local care.

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1. Arrowsmith, S.; Hamlin, E.C.; and Wall, L.L.; "Obstructed Labor Injury Complex: Obstetric Fistula Formation and the Multifaceted Morbidity of Maternal Birth Trauma in the Developing World," *CME Review Article,* Obstetrical and Gynecological Survey, Vol. 51 #9, 1996, pp. 568-574