Obstetric fistula prevention in South Asia
An overview

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The objective of this paper is to present an overview of the measures being taken for the prevention of Obstetric fistula in South Asia with special focus on Pakistan and make recommendations as to what preventive measures should be undertaken in the social/cultural context, health system context and in the medical and clinical context to eradicate obstetric fistula from Pakistan.

Obstetric fistula—a medical condition consisting of an abnormal opening between the vagina and the bladder or rectum—results from unrelieved obstructed labor. [1]

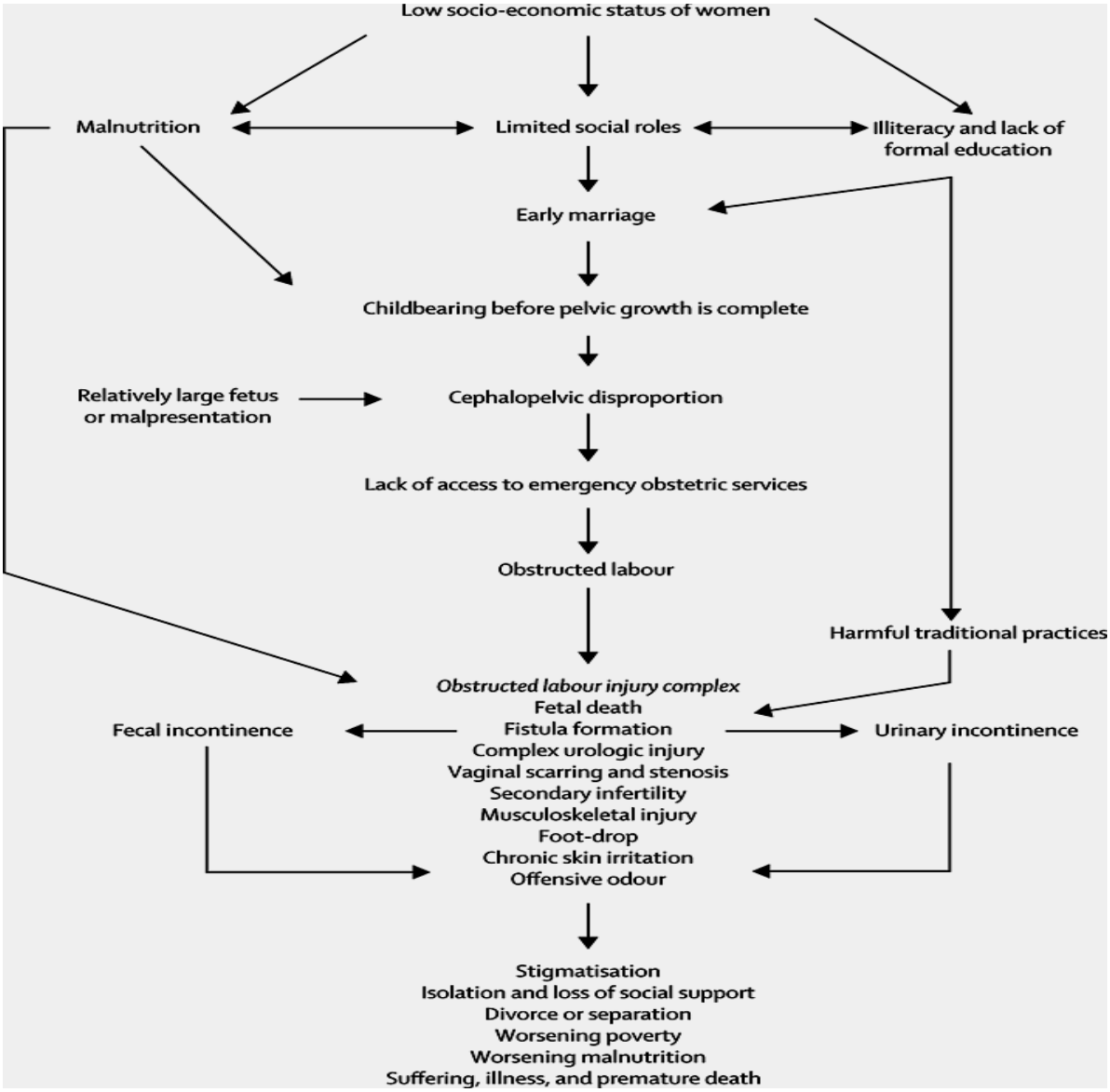
Obstetric fistula is a devastating and preventable tragedy that primarily affects young, poor women who lack the means to access quality maternal care. Women living with fistula are constantly wet from the leaking of urine and often experience genital ulceration, infections and a humiliating odor. About 20 per cent of women with fistula also develop unilateral or bilateral foot drop that limits their day-to-day activities. They are typically shunned by their partners, families and communities because they are considered unclean, and many live in nearly complete isolation. Without financial support, many women with fistula are forced to beg for their living, and they are especially vulnerable to malnutrition and violence. [2]

It is conservatively estimated that more than 2 million women are currently living with obstetric fistula almost all of whom reside exclusively in Africa, South and South East Asia and the Arab region. However the accuracy of this estimate is unknown given that there are almost no reliable data on the magnitude of obstetric fistula at the country level. In addition to these 2 million women living with untreated obstetric fistula, 50,000 to 100,000 new cases occur each year.[3&4] The general public and the world medical community remain largely unaware of this problem. [5 & 6]

Sixty million women in developing world give birth each year without skilled help. Fifty two percent of the women in Pakistan alone give birth without skilled help, i.e., either by a relative or some one else and two percent deliver alone.[7] This exposes them to an extremely high risk of developing post delivery complications including obstetric fistula.

In South Asia the total fertility rate per woman 15-49 years of age is 3.01, 4.26, 3.46 and 5.08; population growth rate is 1.5, 2.2, 2.0 and 2.4; and the percentage of contraceptive prevalence rate (any method) for women 15-49 years of age is 48.2, 39.3, 53.8 and 27.6 for India, Nepal, Bangladesh and Pakistan respectively. [8] The high fertility rate and population growth rate and low contraceptive prevalence rates in these countries as compared to the western world is mainly attributed to the fact that married non professional women in Asia experience significant difficulties in using family planning services largely due to communication problem with health professionals and their low levels of personal autonomy. [9]

Wall's flow chart which is shown below is an explanatory tool showing the interplay of various factors which may lead to obstetric labor injury resulting in Obstetric fistula.



Source: Obstetric Fistula Pathway" (Page. 1205 from Lancet 2006).[10]

Various organizations are active in the campaign to prevent and treat obstetric fistula. UNFPA is the major organization which is active in this field in South Asia. In the second meeting of the working group for the prevention and treatment of obstetric fistula which was held in Addis Ababa from 30th October to 1st November 2002, the UNFPA originally determined that a coordinated effort to reduce the prevalence of fistula through prevention and treatment could be coordinated under the umbrella of a fistula campaign. The vision for the campaign included training, service delivery and advocacy components.

The goals were to prevent new cases of fistula by delaying early marriage and improving access to emergency obstetric care, to improve access to high quality treatment for affected women, to ease social integration of women who have been repaired as well as those who remain affected, and to raise awareness of the problem on an international level. More effort will be required to catalogue the existing services and develop communication networks before embarking on a comprehensive campaign. [11]

FISTULA CAMPAIGN SOUTH ASIA

Moving forward on the agenda to prevent obstetric fistula the UNFPA organized the South Asia conference for the prevention and treatment of obstetric fistula from 9th to 11th December 2003 in Dhaka, Bangladesh. At this conference the country reports for Bangladesh, Nepal, India and Pakistan were also presented. The objective of the conference was to introduce UNFPA's fistula campaign in South Asia, to review current knowledge about obstetric fistula in the region and to discuss steps for moving forward with the campaign in the region. Discussions included strategies for fistula programming, as well as raising awareness among policy makers and developing resource mobilization strategies.

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The conference addressed important interventions which included the following: 1 Improve and expand interventions for prevention and treatment of obstetric fistula. 2 Develop and disseminate messages on fistula for advocacy and awareness raising. 3 Work together to identify a regional strategy for resource mobilization. 4 Ensure integration of fistula related-activities with other programmes. 5 Conduct more research on obstetric fistula to answer identified research gaps. Several immediate steps were identified to spark action in the region which included the following: • Situation analysis/needs assessments, both hospital and community based • South-south cooperation: Developing a database of experts / centers of excellence, conducting study tours, facilitating training, documenting and sharing of best practices / lessons learned • Share existing national clinical protocols. • Partner/stakeholder identification and sensitization • Incorporate messages on fistula into ongoing programmes In addition to the above recommendations, it was suggested that a regional fistula group for South Asia be organized, to meet regularly, to share experiences.

Although almost no specific data on obstetric fistula in South Asia is available, economic and reproductive health indicators suggest that what has been reported likely underestimates the extent of obstetric fistula in the region – except in Sri Lanka, the Maldives and Bhutan, which have reported no cases of fistula
These presentations revealed that a number of studies are now underway in the region and several countries, such as Bangladesh and Pakistan, have begun strengthening access to fistula prevention and treatment.

Bangladesh has achieved notable progress and is now able to provide technical assistance and support to other efforts in the region. Building on these experiences, the group began drafting the elements for a plan of action for

UNFPA to move the *Campaign to End Fistula* forward in the region. The plan of action was shaped around the following key recommendations:

1. Obstetric fistula is a valuable gauge in assessing progress towards MDG 5. It can serve as an entry point to persuade governments to support safe motherhood through allocation of sufficient funds for skilled attendance at birth and timely intervention in case of obstetric complications.
2. Enhanced collection of data, both quantitative and qualitative, is needed in order to determine the magnitude and impact of the problem. Systematic collection of data should be ensured through integration of obstetric fistula in hospital records and health management information systems.
3. Promote integration of fistula prevention and care into ongoing country programs and national safe motherhood initiatives.
4. Networks involving centers of excellence and health professionals working in fistula management should be created with a view to greater regional collaboration.
5. Women living with fistula require comprehensive care that addresses the physical, mental and social consequences of the condition. Due to the poverty of the women most affected by fistula, this care should be subsidized. Where possible, transport and food must be provided for the patients.
6. Fistula is a powerful advocacy example for highlighting poor maternal health in societies. A regional communication strategy is needed, including involvement of celebrities and women who have experienced obstetric fistula.
7. Resources should be mobilized at national level through both donors and budget lines in the public sector to complement funds raised globally.

The report presented at the workshop shows that the success of the Bangladesh programme largely is due to advocacy with policy makers by the country office and close linkages with all aspects of the UNFPA country programme, but also dedicated individuals. As part of prevention efforts, a large scale programme is currently being implemented to train community based skilled birth attendants in collaboration with WHO. Bangladesh has established a fistula treatment unit at Dhaka Medical College Hospital where training also takes place and created a curriculum for health service provider training in fistula management. They have also conducted numerous outreach camps to bring care closer to women and begun decentralizing treatment to regional hospitals. The Centre in Dhaka is also now able to assist other countries with training.

Through discussion following these presentations, participants raised the need to address obstetric fistula as not only a health problem but also as a socio cultural issue. Bangladesh shared its experiences in successfully involving Imams to promote reproductive health with culturally appropriate messages which resulted in frank discussions on a number of sensitive issues. This requires community-level interventions as it has been found that majority of the fistula are occurring in homes, rather than facilities. It was agreed that the Bangladesh experience is an example that reflects possibilities for the region and should be documented for all Campaign countries' benefit.

The two major studies initiated in **India** include the following: The first study entailed a self-administered questionnaire distributed to 6,000 gynaecologists attending the All India Congress of Obstetricians and Gynaecologists. Of the 998 that completed the survey, 91% of respondents reported having seen a fistula at some point during their clinical practice with 66% having seen at least one in the last year. Cases were seen across almost all states – even those with better socio-economic situations – and states with higher tribal populations appeared to have more cases. About two-thirds of respondents noted that fistula patients tend to present within three months of its occurrence, although a number of doctors reported inadequate facilities to provide fistula management.

The second study in India is a cross-sectional prevalence study being undertaken in one district of Maharashtra State**.** The study, due to be completed in 2007, focuses on five chronic obstetric morbidities: 1)vesico/recto-vaginal fistula; 2) uterine/vaginal prolapse; 3) chronic pelvic inflammatory disease; 4) secondary infertility and 5) Sheehan's syndrome. Quantitative and qualitative questionnaires are being administered, including clinical examination in order to estimate prevalence, identify care-seeking behaviors, and to understand the demographic and socio-economic determinants.

In Nepal gave a cross-sectional descriptive study of reproductive health morbidities among married women (age 15-49) that has been nearly completed in seven districts in **Nepal** in collaboration with the WHO. Health camps were held in each of the respective districts based on cluster sampling where questionnaires, patient histories, and patient examination and laboratory investigation forms were completed for each woman meeting inclusion criteria.

Treatment was provided for each woman accordingly. The study found high prevalence of prolapse and STI's and only five cases of obstetric fistula among the sample of 1,998 women. The findings suggest the need for a programme to improve detection, prevention and management of reproductive morbidities at district level, particularly uterine prolapse.

In **Afghanistan** only a rapid assessment of facilities for fistula treatment service delivery in Kabul has been conducted and a survey of midwives is planned in the future. Although there are potentially enormous needs in Afghanistan, however initially fistula treatment services are planned to be started on a smaller scale in one centre in Kabul, and then expanding services later through outreach camps and eventually decentralization of services to the other regions.

The maternal health situation in **Pakistan** illustrates the need for investment in maternal health care, particularly to address discrepancies between rural and urban areas. While data on obstetric fistula is scarce, it is estimated that potentially 5,000-8,000 new cases occur each year. Yet, tertiary care facilities report receiving only 20-30 cases annually. Launched in January 2006, the UNFPA campaign in Pakistan is intended as part of national efforts to reduce

maternal mortality and morbidity. A three-year project includes establishing four regional fistula repair centers; making services more accessible through outreach camps; and promoting safe delivery and quality emergency obstetric care. Several health professionals will receive training at the centers in Addis Ababa and Dhaka and a network of professionals involved in fistula treatment and care will also be established.

Among the action plans for different countries which were prepared during the UNFPA workshop in 2006, the one for Pakistan included the following; The first component was related to Improved data collection and suggested **1.**To include questions on obstetric fistula in upcoming DHS. **2.** Utilize system of 100,000 Lady Health Workers (LHWs) which covers 70% of country for community surveillance and Improved data collection **3.** Conduct a survey of OB/GYN for secondary data from secondary and tertiary level health facilities. The second component included Enhanced commitment to maternal health which entailed **4.** Identify celebrity spokespersons **5.** Develop regionally focused films for advocacy, use for advocacy in seminars or to run on private TV channels. **6.** Organizing sensitization seminars for policy makers, NGOs and service providers. **7.** IEC material produced for dissemination to policy-makers, NGOs, service providers. The third component deals with Improved access to prevention, treatment and rehabilitation services and entailed **8.** Implementation of the project funded by the UN Trust Fund for Human Security. **9.** Increase number of regional centers to six. **10.** Modify design of the project in order to expedite the implementation. [12]

CONCLUSION

All the available literature on South Asia and particularly Pakistan shows that still there are many gaps which need to be filled through detailed research on prevalence of obstetric fistula and at the same time work on preventive measures. In light of the overview presented in this paper the following recommendations are made:

A. The Cultural or Social Context

Sensitization of the women at the village level is very important. Other preventive measures include the following:

- **To improve the status of women and girls** and work for **Poverty alleviation through micro credit programs.**
- **Provide improved nutrition to combat malnutrition.**
- **Ensure universal formal education for girls.**
- **Educate all** opinion leaders in the families, communities and at the national level **to avoid early marriage and early maternity.**
- **Educate** regarding **abandoning of harmful traditional practices** such as FGM (But this not common problem in South Asia).
- To **Link Fistula with Gender and Equity issues.**
- Availability of **Social Rehabilitation** Services.

B. Health System Context

As "Women with Fistula are living indicators of failed maternal health systems". Therefore following preventive measures should be taken:

- Availability of **Emergency Obstetric Care Services** like Cesarean Section in case of obstructed labour.
- Availability of **Improved transportation in Rural Areas**.
- **Accessible and affordable Family planning services** at the door step.
- Dissemination of **Information regarding** the availability of **fistula treatment services**
- Development of **sufficient trained personnel**
- Development and **dissemination of communication materials regarding awareness of preventive measures.**
- **Provision of resources** for Fistula repair.

C.The Medical/Clinical Context

- Provision of **standardized antenatal care services** with special emphasis on **regular antenatal visits** and counseling regarding **delivery by a trained health professional who has a linkage with a health facility which has services available for emergency obstetric care.**
- Improvement of labour management techniques: Such as **use of partogram** that assists midwives and doctors to plot the progress of labor and take appropriate action at the appropriate time; **Post delivery catheterization in case of obstructed labour**; Availability of skilled **personal and infrastructure for performing Cesarean Section** when required **can serve as preventive measures.**
- **Availability of Fistula repair facilities** and access to **Specialist care** when required.

As is evident from the data on Pakistan that fifty two percent of the deliveries are done by unskilled birth attendants and two percent of the women deliver alone. Therefore the need to develop communication materials for educating the special target groups is essential in order to prevent obstetric complications including obstetric fistula. The use of Mohalla Sangat programmes to create awareness about the preventive measures related to obstetric fistula and at the same time promote family planning and safe delivery education can prove to be an effective strategy for prevention of obstetric fistula..

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