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Reproductive Health Problems in the World: Obstetric Fistula: Background Information and Responses

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Summary

Obstetric fistula has gained increased attention in the 108th Congress when a number of briefings were held to discuss the impact of this debilitating condition on millions of women. Additionally, H.Con.Res. 447 and H.R. 3810, were introduced to recognize the effects of the affliction, and to reserve a portion of the U.S. contribution to the United Nations Population Fund (UNFPA) for fistula prevention and repair. Finally, P.L. 108-199, *2004 Omnibus Appropriations,* provides $1 million to the International Medical Corps to expand its fistula repair services in Sierra Leone. It also supports the establishment of airborne medical transport services in Africa to fly medical personnel, supplies, and anti-retro viral therapies to rural areas on a regular schedule.

It is estimated that at least 2 million women and girls suffer from this affliction worldwide. Fistula occurs from prolonged labor, particularly when labor lasts two days or more. When a woman or girl is unable to push the baby out, the pressure from the baby's head can interrupt blood flow to tissues in the pelvic area. Ultimately, the woman passes the baby after it dies, as the decomposed body is smaller than the live one. After pushing for a number of days a hole develops in the tissue between the vagina and bladder (and at times the rectum), causing incontinence. Fistula survivors can also suffer nerve damage, which can make walking difficult. Women with this condition are stigmatized and usually shunned, due to their strong odor. Some are abandoned by their husbands on whom they are financially dependent, and are forced to leave their homes. Many live a life of solitude. Those who are cast out often resort to begging, and in some cases sex work. This report will discuss the prevalence of this condition, the impact that the condition has on affected girls and women, and describe efforts of USAID and other organizations to raise awareness, prevent, and treat fistula.

Obstetric fistula occurs almost exclusively in developing countries, mostly because women in the most affected countries have minimal access to safe maternity care and caesarean sections. Ill-equipped health care systems struggle to meet the basic needs of their populations, and maternity and reproductive health care is reportedly frequently

underfunded. As a result, many women deliver at home without skilled birth attendants, increasing their risk for developing fistula.

This affliction occurs most often among girls aged 15-19 years old, whose pelvises have not finished growing. In many rural areas, girls are married just after they experience their first menstrual flow, usually between the ages of 10 and 15 years.[1] The young girls who are affected are also often poor and malnourished. The girls' pelvic size can also be small due to malnourishment, which can cause stunting. The combination of youth and stunting makes young girls more vulnerable to the condition. For example, in Niger, 80% of fistula cases occurred among girls aged 15-19 years.[2]

It is unknown exactly how many develop fistula, because many women labor outside of facilities and many countries do not record cases. The World Health Organization (WHO) estimates that at least 2 million girls and women are living with fistula, and that an additional 50,000 to 100,000 are affected each year. However, the United Nations Population Fund (UNFPA) believes the estimate is too low, because it counts only patients who seek treatment.[3] The uncounted include the many women in affected countries who do not have access to medical centers, and must walk up to three days to the nearest facility. Other estimates seem to support UNFPA's assertion. The Nigerian Ministry of Women's Affairs estimates that some 800,000 women await treatment, while some 8,500 Ethiopian women are believed to develop the condition annually.[4]

Fistula repair and prevention are difficult to secure in many developing countries for a number of reasons. First, cost can be a prohibitive factor. Additionally, many health centers in the most affected areas (sub-Saharan Africa and South Asia) lack funding, trained professionals, basic equipment, and surgical supplies to conduct the repair surgery. Furthermore, the expense and shortage of skilled birth attendants, and minimal access to cesarean section further complicate efforts to prevent obstetric fistula.

U.S. and International Response

Some organizations work to prevent and repair obstetric fistula, which is largely unknown in the Western world. Below is a brief description of the activities that a few institutions have developed.

U.S. Agency for International Development (USAID). USAID has implemented projects to prevent obstetric fistula since 1989, as part of its maternal health programs. Key activities in the programs seek to:

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[1] UNFPA and EngenderHealth, "Obstetric Fistula Need Assessment Report: Findings from Nine African Countries." 2003. [http://www.unfpa.org/fistula/docs/fistula-needs-assessment.pdf]

[2] World Health Organization (WHO), "Delay Childbearing." World Health Day: Safe Motherhood, April 7, 1998. [http://www.who.int/archives/whday/en/pages1998/whd98_04.html]

[3] UNFPA Press Release, *"New Report Maps Fistula in Africa."* June 18, 2003. [http://www.unfpa.org/news/news.cfm?ID=335&Language=1]

[4] Kristof, Nicholas, *"Alone and Ashamed."* The New York Times. May 16, 2003. [http://www.fistulahospital.org/article.html]

- increase access to emergency obstetrical care;
- raise awareness and disseminate information about the affliction;
- train traditional midwives, family members and others who may be influential in deciding when a woman should receive additional care; and
- improve capacity of skilled health care practitioners.

Information and awareness raising is a critical factor in fistula prevention. Related programs promote the postponement of marriage until after the teen years, raise awareness about the risks of prolonged labor, encourage labor-related emergency preparedness, and educate traditional midwives and men (who often decide when and if a woman can seek medical assistance) to identify the danger signs of obstructed and/or prolonged labor.

In 2004, USAID will expand its obstetric fistula program through the addition of treatment assistance and data collection. Additional activities will seek to:

- expand data collection capacity related to the causes, prevalence and severity of obstetric fistula disability;
- improve public and community awareness about causes, and medical and social consequences of obstetric fistula;
- augment services for the prevention and treatment of obstetric fistula; and
- support advocacy and policy efforts for improved access to safe delivery and care in cases of obstetric complications.

United Nations Population Fund (UNFPA). For more than thirty years, UNFPA has been engaged in providing reproductive health education and services. A key part of the organization's work has been to advocate for policy changes that would improve women's reproductive health, and ultimately prevent occurrences of obstetric fistula. Its programs include activities to:

- assist projects that provide young girls and women with family planning information and services;
- train traditional birth attendants and midwives to recognize obstructed labor;
- increase women's and girls' access to health care, including skilled birth attendants and antenatal care;
- facilitate transportation to expert medical facilities for complications during labor, such as prolonged and obstructed labor;
- support counseling and social rehabilitation of fistula survivors;
- advocate legal and social changes to improve the status of girls and women, including the postponement of marriage; and
- educate men about fistula and the importance of prompt care in cases of prolonged and/or obstructed labor.

In addition to its activities related to preventing obstetric fistula, UNFPA, together with the International Federation of Obstetrics, and Gynecology (FIGO), Columbia University's Averting Maternal Death and Disability Program (AMDD), and other non-governmental organizations (NGOs) have developed a working group. The group aims to raise awareness about the issue, advocate for supportive policies, increase resource allocations to maternal health, provide strategic support, assist health care providers to

receive training, and establish services for fistula repair. Correspondingly, UNFPA, FIGO and AMDD have each pledged $750,000 to fund an international campaign against fistula, which began in July 2001. One of the first outcomes of their campaign has been the release of a report documenting how health care facilities cared for women with fistula in nine countries in sub-Saharan Africa. The report was the first survey documenting the ability of local facilities to respond to fistula needs across the region.

The consortium plans to continue its research and report on the breadth of cases in other African countries and south Asia. Although researchers visited nine countries, they were unable to estimate the actual number of women affected, as fistula is rarely recorded in provider logs, and information on prevalence has never been compiled. One reason, researchers found, is that fistula repair is seen as a luxury surgery, given that the woman will not die without the surgery. Additionally, researchers found that many women did not know that treatment was available. For example, in Chad one hospital reported that it conducted twenty-four fistula surgeries per year. However, within one week of launching an awareness campaign, which announced that fistula repair surgery would be conducted, seventy women requested treatment.[5]

UNFPA also supports existing fistula treatment centers in Ethiopia, Nigeria, and Tanzania, as well as the development of new ones in Ghana and Uganda. One UNFPA-supported center, the Hamlin Fistula Hospital in Ethiopia, treats 1,200 women per year, with an annual operating cost of $400,000.[6]

Local Health Care Facilities. There are a number of public, private, and faith-based health facilities that repair fistula. Zomba Central Hospital, a public sector facility in Malawi, struggles to meet the needs of the women in the community. Women reportedly share beds at this facility in order to increase the number of women served. Worldwide Fund for Mothers Injured in Childbirth (WFMIC), a faith-based organization, has sent visiting surgeons to operate throughout Africa, has built fistula centers in Nigeria, and will soon expand to Ghana.[7] Other facilities include Hospital National de Niamey in Niger, Hospital Provincial de Quelimane in Mozambique, Kitovu Mission Hospital in Uganda, Monze Mission Hospital in Zambia, Kenyatta National Hospital in Kenya and Lira District Hospital in Uganda.

Key Challenges

Cultural Barriers. It has been argued that postponing marriage, and ultimately pregnancy would decrease incidence of obstetric fistula. However, in many countries a girl is eligible for marriage once she menstruates. Marriage is not only a celebratory cultural practice, but it also has economic implications in many rural societies. The practice of paying a "bride price" remains common in many parts of the world,

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[5] UNFPA and EngenderHealth, "Obstetric Fistula Need Assessment Report: Findings from Nine African Countries." 2003, p.17. [http://www.unfpa.org/fistula/docs/fistula-needs-assessment.pdf]

[6] For more information on the Hamlin Fistula Hospital go to [http://www.fistulahospital.org].

[7] Information about the local hospitals were compiled from interviews with staff of EngenderHealth on March 11, 2004. For more information on WFMIC go to [http://www.wfmic.org].

particularly Africa. The family of the bride receives a compensation for a girl upon marriage, most often in the form of money, cattle or other prized resources. The family that weds the girl benefits by gaining a food producer. Girls and women are particularly important in traditional agrarian societies, especially in Africa where 80% of subsistence farmers are women.[8] Additionally, the family gains one who can increase the size of the family through procreation.

In areas that have a "bride price" tradition, a girl may be viewed as an additional financial burden when a family postpones her marriage. Concurrently, if a young girl postpones pregnancy then there is less support in labor-heavy agricultural work. Consequently, critics argue that convincing people in agricultural societies to delay marriage and pregnancy would be a significant educational exercise, and would require cultural change with considerable economic impacts.

Local Capacity. Obstetric fistula repair surgery requires trained medical staff and surgical equipment, both of which are difficult to secure in limited-resource settings. Many developing countries face significant "brain drain" challenges. The few medical professionals who are well-trained are often attracted by higher salaries and better working conditions in other countries. For example, it is estimated that between one-third and one-half of all South African medical school graduates emigrate to the developed world, costing the country an estimated $184,000 per professional. Paradoxically, it is estimated that Africa spends about $4 billion per year on the salaries of 100,000 foreign experts.[9] The movement of skilled health professionals to other countries or private clinics exacerbates medical staff shortages due to other causes, such as limited specialized medical and educational facilities and the inability of many to pay for advanced training.

Analysts point out that it is difficult for countries with struggling health care infrastructures to prioritize treating obstetric fistula when they struggle to offer basic health care. A number of countries struggle to maintain an inventory of such basic supplies as latex gloves, hypodermic needles, and anesthesia. While in high-income countries an average of 8% of national income is spent on health ($1,000 to $4,000 per capita), low-income countries spend between 1% to 3% of GDP for health; the latter may only be between $2 to $50 per capita. Thus, even with significant increases in health care spending, only rudimentary health care would be available for the general population.[10]

Sustainable Funding. Fistula repair costs between $100 and $400, an affordable cost for most in industrialized countries. However, in many of the most affected countries the cost of the surgery exceeds annual family income. Thus, women and girls who suffer from fistula will most likely rely on international programs that offer repair surgery. Critics argue that this is not a sustainable solution. It has been said that more funds should be spent on building health infrastructure instead of mostly treating diseases. A

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[8] World Economic Forum, *"African Food Security: A Role for Public-Private Partnership."* Africa Economic Summit 2003 website, December 6, 2003. [http://www.weforum.org]

[9] Pang, Tikki, *"Brain drain and health professionals."* British Medical Journal website. BMJ 2002;324:499-500 (March 2). [http://bmj.bmjjournals.com/cgi/content/full/324/7336/499]

[10] World Health Organization, *Health Systems: Principled Integrated Care*, p. 120. 2003. [http://www.who.int/whr/2003/en/Chapter7-en.pdf]

shortage of funding is a key obstacle to expanding care to the millions of women affected by obstetric fistula.

Limited local expertise on fistula repair also inhibits the ability to respond to the need. Observers emphasize that the reliance on foreign surgeons for fistula repair surgery increases the related costs and minimizes the number of women and girls who can be helped. Critics point to the $1 million appropriation to the International Medical Corps. They argue that while the funds will serve to increase the number of women able to receive assistance, only a limited number of women will be helped due to the relatively high salaries of foreign doctors and other related expenses. Thus, some advocate increased funding for building local capacity.

Other Reproductive Health Programs. Proponents argue that support for other programs that impact women's health need greater funding. Some point to small increases in USAID family planning and reproductive health spending since FY1999. USAID received $381 million in funding for its family planning and reproductive health programs in FY1999, which by FY2004 had increased by $65.5 million to $446.5 million. Similarly, funds for child survival and maternal health programs rose by $18 million from $312 million in FY1999 to $330 million in FY2004. Some are concerned that support for HIV/AIDS programs have overshadowed critical challenges in reproductive and maternal health care. Globally, USAID spending on HIV/AIDS rose from $139 million in FY1999 to $516.5 million in FY2004, an increase of $377.5 million. Proponents argue that increases in maternal and reproductive health funding should parallel those of HIV/AIDS programs, as advances in those fields are inextricably linked to the prevention of the virus.

The President of EngenderHealth, a non-governmental organization that focuses on women's health worldwide, recently stated at a congressional briefing that the women who face high maternal morbidity rates, unintended pregnancies, fistula, and other maternal health complications are the same women who are likely to contract HIV.[11] A recent study undertaken in Kenya demonstrated that reproductive health and HIV/AIDS funding often have an inverse relationship. The study found that spending for population and family planning fell from $12 million in 1995 to $6 million in 2001, while funding for HIV/AIDS programs rose from $2 million in 1995 to nearly $12 million in 2001.[12] It has been argued that increasing HIV/AIDS spending while maintaining or reducing support for maternity health and health care infrastructures, risks seeing a rise in fistula, maternal morbidity, and a range of other reproductive health problems. Some argue that family planning, maternal health and reproductive health care programs should be integrated into HIV/AIDS programs.

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[11] Amy Pollack speaking at *"Meeting the Health Needs of Women in the Era of HIV/AIDS."* March 4, 2004, Rayburn House Office Building, Room B-338.

[12] Pollack, Amy, "Family Planning and HIV Prevention: A Close Look at Kenya." March 4, 2004. [http://www.globalhealth.org/assets/advocacy/pollack_030404.pdf]

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