Join Hands to Eliminate Obstetric Fistula - Campaign in Nepal

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Abstract

This paper is intended to draw attention of those health care professionals and policy makers who are the reproductive health care planner, advocates and service providers about the women during the reproductive years and beyond. The paper call on the initiation of steps to eliminate obstetric fistula(OF) and its preventive aspects in Nepal where case identification and management is very difficult task because of the women are isolated and divorced due to continuous leakage of urine and feaces. In Nepal there are 281 maternal mortality out of every one million cases. Moreover, 5.6 % of those deaths are caused due to obstructed labor. Each year 200-400 cases of fistula are estimated in Nepal i.e. 0.3 to 0.6 per 1000 deliveries(Source: report of regional consultation meeting, UNFPA 2011).

The basic focus is in National Surveillance System for Fistula which should come up with a national and local group of dedicated professional volunteers to advocate for prevention and management of OF and to act as leaders and advocates for rehabilitation and reintegration of treated cases. It also serves to develop and strengthen capacities of the health professionals on issues related to OF, prevention and its treatment.

The three proven interventions to reduce maternal mortality and morbidity are family planning, skilled care at every birth, and access to emergency obstetric care to prevent deaths and disabilities resulting from complications of pregnancy. Hence UNFPA/ WOREC Nepal, INF (International Nepal Fellowship) and professional associations are working together to eliminate OF in Nepal since 2010.

Introduction

The trauma, pain and agony of a patient suffering from Obstetric Fistula (OF) can hardly be expressed in words. This debilitating morbidity is often a result of circumstances, beyond the control of the poor victim, that are often preventable. The consequences of this condition are physical, social, economical and profoundly psychological, with many sufferers being labeled as social outcastes. The three proven interventions to reduce maternal mortality and morbidity are family planning, skilled care at every birth, and access to emergency obstetric care to prevent deaths and disabilities resulting from complications of pregnancy. The major pillars to fight against fistula such as Prevention, Complete management of cases (identification, surgery, nursing and counseling), social reintegration, training and research.

Obstetric fistula is caused by prolonged labor without prompt medical intervention, usually a caesarean section. During the prolonged labor, the soft tissues of the pelvis are compressed between the descending baby's head and the mother's pelvic bone. The lack of blood supply causes tissue to die, creating a hole between vagina and bladder (known as a vesicovaginal fistula), or between the vagina and rectum (causing a rectovaginal fistula) or both. The result is a leaking of urine or faeces or a combination of the two. The woman is left with chronic incontinence and, in most cases, a stillborn baby. Fistula, like many other RH

morbidities, is an avoidable and preventable tragedy. It shatters the life of the woman and leaves her with a lifelong disability. Very often such women are forced out of their families to lead a life of pain, suffering and despair.

This problem has not extensively been researched in Nepal. However, most recent research has discovered that there are almost two million Obstetric Fistulas in the world, among which all of them are divided in the Sub-Saharan or South Asian countries. In Nepal there are 281 maternal mortality cases out of every one million cases. Moreover, 5.6 % of those deaths are caused due to obstructed labor. Each year 200-400 cases of fistula are estimated in Nepal i.e. 0.3 to 0.6 per 1000 deliveries. Obstetric Fistulas is a neglected aspect in the struggle to end violence against the women. It causes them physical discomfort but also mental disability and many patients won't be able to reach out to others; therefore it is our duty as health care providers and women's right activists to reach out to them.

With reference of the Programme of Action of the 1994 International Conference on Population and Development (ICPD), agreed by 179 countries, positions reproductive health, including family planning, and the healthy relationships and well-being of individuals, as a right. To ensure that Sexual and Reproductive Health of the women UNFPA is supporting evidence based advocacy and health care delivery system in partnership of Nepal government at present. Each year thousands of women in many countries of the region suffer from Fistula and the problem is further compounded by the lack of credible information about these cases.

Maternal health and Obstetric Fistula status in Nepal:

Maternal mortality in Nepal is 281 / 100,000 live births and death due to obstructed labor is still 5.6% ,Fertility has decreased from an average of 4.6 births per woman in 1996 to 4.1 in 2006 and now 2.6 in 2011. ANC first visit has increased to 87.4% ,.Institutional Deliveries is 35 %, delivery by SBA is 36 % Met need of EOC 29% and CS 67%, but no data for OF is available.

Historically, the study findings shows that OF is prevalent in Nepal where opérations were reported in Patan Hospital 487 cases , 23 cases in BPKIHS Dharan(2008) and évidence of INF supported Fistula camp in Surkhet (2009) and operated 77 cases (2011). The Incidence of OF in 2011 was 0.3 to 0.6/ 1000 delivery and expected new cases in 2011 was 200 -400. The prevalance of cases in 2011 was 4362 cases.(Source: Facility Need Assessment study 2011, Nepal)

Prevention and Management

While prevention is the best line of treatment for such a condition, treatment is often a tedious and lengthy process, with little assurance of success. The major ***five pillars*** to fight against OF are:

1. Prevention
2. Complete management of cases (identification, surgery, nursing and counseling)
3. Social reintegration
4. Training
5. Research on obstetric fistulas

1. Preventive aspects:

Improve the status of women with education and availability of family Planning access which will provide information and services to help them delay childbearing or space births would help reduce complications of child birth.
Delay age of marriage and pregnancy reduces

the number of adolescence pregnancies. Many fistulas occur to adolescent girls , whose bodies may not be fully developed for child bearing.

Improve quality access to obstetric care such as antenatal care and universal use of Partograph including emergency care ,skilled attendance and timely referral for risk cases helps women to avoid obstetric fistulas.

Access can be improved by avoiding the three delays i.e deciding to seek care, reaching to health facility and receiving sufficient care at the facility for assisted or operative delivery.

Avoid manipulation during labor management and use of urinary catheter in difficult labor-when a fresh OF is diagnosed which promotes healing of necrotic lesions (after prolonged obstructed labor) and also spontaneous healing (or reduction in diameter) of simple 'fresh' vesico vaginal fistulas (VVF).

2. Complete management of cases

Currently, very few hospitals or surgeons offer fistula-repair services because of lack of facilities, capacity or trained staff. Even if a woman reaches a facility able to offer repair, these operations are often not regarded as emergencies and slip down the already busy operating-theatre list. Such facilities may also lack the capacity to care for the woman for a prolonged period of time. Until OF repair and rehabilitation becomes a routine part of the work of any hospital, alternative strategies need to be developed.

The key to elimination of obstetric fistula is provision of skilled birth attendants at all births, availability of EmOC. However, a vital component is the issue of finding existing cases and providing treatment to them. Clear communication and psychological counseling the woman and family members are very important, case management includes the procedures from the admission , diagnostic test, peri operative care post op instructions ,discharge and follow up. Sometimes special counseling care is needed to different group of women.

3. Social Reintegration

Women who have been successfully treated for fistula could be trained to help with community outreach. For all fistula survivors, education and counseling are needed to help restore their self esteem and allow her to reintegrate into her community once she is healed.

4. Training

As with other parts of the fistula strategy, there is both a need to address the immediate problems of training staff to undertake fistula repair, or provide other essential services, whilst simultaneously developing a sustainable long-term programme these includes :

- Undergraduate training for all health professionals, social workers and other professionals allied to medicine.
- Post-graduate training for obstetricians, midwives, nurses, surgeons, clinical officers, general practitioners and others who may be caring for pregnan women in labour and/or those who have developed OF.
- Basic, supervised, surgical training in simple fistula repair for those who will be able and authorized to undertake such repairs once competent.
- Training for nurses, midwives, physiotherapists, counsellors and social workers who will be providing the integrated care required for the management and rehabilitation of women undergoing OF repair.

- Specialist training for obstetricians or surgeons who, once able to undertakesimple repairs, will become 'experts' in complex fistula repair, who will be able to manage the most complex cases, act as specialists to whom other surgeons can refer, and act as trainers for more junior or inexperienced staff.

Pre-service curricula

The pre-service curriculum must include a basic understanding of OF, its causes, its management and, most importantly, its prevention. The programme should also include a wider social and cultural understanding of both the root causes of fistula and its implications for affected women. It should stress the need for all pregnant women to seek skilled care both in the antenatal period and during childbirth. It will also include more clinical issues such as the identification of prolonged or obstructed labor.

5. Identify research gaps and generate ideas for possible OF research/studies to take place.

Knowing the prevalence of women living with fistula, It is also necessary to understand the underlying determinants that lead to fistula. The causes may well be multi-factorial but often relate to access to services during complicated or obstructed labors. The retrospectively or prospectively study , through community-based or facility-based case reviews will help to delineate the particular issues with confidential enquiries into maternal deaths and clinical audit. Reviewing the cases of women living with fistula in the community will help to determine any personal, family or community factors that led to the fistula formation or why the woman did not seek treatment for the fistula once formed. Community-based surveys require the cooperation of the women, their families and communities, and need particular sensitivity to avoid appearing to apportion blame. Case reviews should be action oriented.Facility-based reviews are easier to undertake, as the women will have gone to a hospital for management of obstructed labour or fistula repair.

In conclusion, No woman should suffer from OF which is preventable and treatable. Most of them suffer in silence for many years before they are accidentally discovered by the system. The lack of national databases on this morbidity points to the weakness of the system and needs to be addressed urgently. This is where the concept of *surveillance* assumes significance. Communication + advocacy are essential programming tools to eliminate Obstetric Fistula, so expansion of **awareness raising** on prevention and treatment is vital.

References

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