Double burden of tragedy: stillbirth and obstetric fistula

Since the publication of The Lancet Stillbirths Series in 2011, attention to the more than 2·6 million stillbirths that occur every year has become more visible in global and national maternal and neonatal health strategies. However, we continue to neglect the millions of women who experience not only stillbirth, but also a related tragic outcome—obstetric fistula from the underlying common risk of obstructed or prolonged labour complications. Losing a baby to stillbirth is surely one of the saddest experiences a woman can have in life; ending up with the traumatising disorder of obstetric fistula is twice as life-shattering.

Our meta-analysis of obstetric fistula studies published between 1990 and 2015 shows that 90·1% (95% CI 90·2–91·0) of pregnancies in which the woman develops fistula result in stillbirth (figure). Studies suggest that risk of stillbirth is 99 times greater when women develop fistula than if they have a normal delivery.1

Among all maternal morbidities, obstetric fistula is considered the most devastating. The constant leakage of urine, faeces, or both cause women who have a fistula to be frequently abandoned and ostracised. Physical and psychological sufferings adversely affect the quality of women’s lives in such a catastrophic way that they are sometimes described as dead women walking.2

Since the initiation of the Campaign to End Fistula by the UN Population Fund (UNFPA) and partners in 2003, awareness among policy makers has increased greatly. However, little progress has been made in eradicating fistula, which was virtually eliminated in Europe and the USA 100 years ago. With a concerted effort, it will also be possible to rid low-income countries of obstetric fistula. We underscore the crucial need to address four strategies to achieve this goal.

First, there is a critical knowledge gap about the burden of obstetric fistula. It has been estimated that between 1 million3 and 3·5 million4 women currently have fistula in sub-Saharan Africa and southeast Asia. The wide variability in estimates suggests that the actual prevalence of fistula is unknown. The reliable estimation of global maternal mortality and stillbirths has helped to draw attention to these two major, but neglected, public health problems. A similar global effort is needed for assessing fistula prevalence and incidence.

Second, there is an urgent need to expand access to surgical care for obstetric fistula, which is currently abysmally low. The Lancet Commission on Global Surgery highlighted “gross disparities in access to safe surgical care worldwide”, estimating that about 5 billion people have no access to surgical care.5 With the UNFPA-led Campaign to End Fistula, Fistula Foundation, and USAID-supported Fistula Care Project the number of fistula repair surgeries has increased substantially during the past decade. However, at the current rate, we estimate that fewer than 1% of women and girls in need of such treatment will receive it. Thus, most women and girls living with fistula today will die before ever having the opportunity to be healed from this highly preventable and treatable disorder.

Third, fistula prevention must be an integral part of national maternal and newborn health strategies. Fistula is preventable with timely access to emergency obstetric care, especially caesarean section. Home births, absence of skilled birth attendants and transportation to emergency obstetric care facilities, poor labour progression monitoring without partograph, inadequate surgical capacity, and lack of prenatal care and family planning are the predominant risk factors for both obstetric fistula and stillbirths. Although the duration of labour is typically 12–16 h, many studies suggest that women who developed fistula endured 2·5–4·0 days in labour.6 Much more needs to be done to improve monitoring of labour progression and recognition of obstructed labour, ensure quality and availability of caesarean deliveries, and expand referral systems to enable women to seek timely care for caesarean sections or assisted deliveries at health facilities.

Fourth, social rehabilitation and reintegration of patients with fistula along with community sensitisation (to prevent the occurrence of fistula, as well as to mitigate against stigmatisation of fistula survivors) will be crucial to eliminate obstetric fistula. Many women might not seek surgical care for fear of stigma in the community.7 Studies show many surgically repaired women serve as volunteers to identify and refer other cases in the community for surgical treatment. Access to treatment, social support, and rehabilitation will profoundly improve their physical and mental health, and provide a second chance of family life and a life
of dignity, hope, and healing. We must break the cycle of poverty, vulnerability, and exclusion that renders women and girls susceptible to fistula in the first place.

As the global community mobilises around the Sustainable Development Goals and recently launched Global Strategy for Women’s, Children’s and Adolescents’ Health (2016–30), ending preventable maternal and newborn deaths has moved from a seemingly distant dream to a concrete, actionable goal. When we speak of ending preventable deaths, including stillbirths, let us not forget the human rights imperative of ending the egregious suffering of those women and girls with fistula.

The UN Secretary-General has called on the global community to end fistula in our lifetime. To do so is

For the Global Strategy for Women’s, Children’s and Adolescents’ Health see http://www.who.int/life-course/publications/global-strategy-2016-2030/en/

See Online for appendix

Figure: Percentage of stillbirths in deliveries in which obstetric fistula developed
Studies listed in appendix.
indeed within our reach, yet it requires substantially increased political and financial commitment and accelerated global action and accountability.

*Saifuddin Ahmed, Erin Anastasi, Laura Laski
Johns Hopkins University Bloomberg School of Public Health, Baltimore, MD 21205, USA (SA); and UN Population Fund, New York, NY, USA (EA, LL)
sahmed@jhu.edu

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