

Supporting surgery for obstetric fistula

A pioneering centre in Ethiopia that tackles the burden of fistula has become a blueprint for similar services elsewhere in Africa and Asia

Obstetric fistula is rare in Western countries, thanks to the wide availability of caesarean section, but the potentially devastating childbirth injury continues to affect an estimated two million women throughout the developing world.

This type of fistula arises from ischaemia during prolonged obstructed labour. Fistulas can form between the vagina and bladder or rectum, causing continuous leakage of urine or faeces.

Poverty is the main risk factor for fistula, which the World Health Organization has called “the single most dramatic aftermath of neglected childbirth.” Most women have little or no access to antenatal or obstetric care, and, once injured, nearly all go untreated, although surgery can cure fistulas. Because of the smell of urine and their inability to have children, the women are often cast out from their communities and left to fend for themselves.

There are 100 000 new cases of such fistulas every year worldwide, but only about 6500 are treated. The Addis Ababa Fistula Hospital is now set to open the first of five regional centres in Ethiopia, paid for by fund raising (from charitable trusts in the United States, the United Kingdom, Australia, and Norway), to treat women with fistula and provide emergency obstetric care.

The programme developed by Australians Dr Catherine Hamlin and her late husband, Reginald, has become the model treatment across the developing world for obstetric fistula. Patients at the hospital now have a 93% success rate—at the cost of \$180 (£100; €140) per case.

Dr Andrew Browning, one of five surgeons at the centre, puts their work into context.

“Obstetric fistula has only come into significance as a health problem because of the Hamlins’ work. Their efforts over 45 years brought the issue to the attention of the World Health Organization and the United Nations Population

Fund. They [the Hamlins] have treated around 25 000 patients, but they have also trained 100 surgeons who have gone back to their own countries to set up centres.”

Both WHO and the population fund now have initiatives aimed at reducing the number of cases of obstetric fistula. The fund directly supports the Fistula Foundation in New York but has also spearheaded an “End Fistula” campaign in 30 countries, equipping hospitals with the necessary surgical supplies and helping women to integrate themselves back into communities after treatment. Those countries include Nigeria, Kenya, Bangladesh, Pakistan, and Mozambique.

The Addis Ababa Fistula Hospital offers free surgery and rehabilitation to patients until they are ready to return to their communities. Women who cannot return to their villages because their injuries are too severe to be repaired are fitted with stomas and rely on urostomy or colostomy bags. They can stay in hospital accommodation and are given the option of training as nursing aides. Their personal experience of fistula makes them more sensitive to the specialised needs of the patients, says the hospital.

An ongoing study of the mental health of patients has found that 97% of patients have been depressed. “It’s not surprising,” says Dr Browning. “They have been through a long, horrible labour. It has taken on average 26 days before they can even walk again, they have lost their baby, been rejected by their husband.”

Despite its fame the hospital can treat only a small percentage of new cases each year, says Dr Browning. “Even in Ethiopia, where we treat around 1200 women a year, we think there are 9000 cases in this country alone.”

But training has inspired foreign surgeons to establish fistula repair centres or wards in countries where treatment was previously unavailable. Karachi,

Pakistan, for example, has no fistula hospitals, but surgeons now regularly operate on fistula patients, although the work remains a low priority.

Dr Shereen Bhutta, chief of obstetrics at the Jinnah Postgraduate Medical Centre, says the women often feel very neglected and ostracised by other patients. “Inspired by the Hamlin model we have raised money from philanthropists to construct a hostel for fistula patients, which should be ready next year. No one wants to sit next to them or eat with them. There is no room to separate them in the hospital.

“Their stay is quite long, at least a month, so it is not a case of coming in for a few nights then going back home. They are in terrible shape and require building up so they are fit to undergo surgery. Even afterwards they have to wait two to three weeks before going home.”

Dr Bhutta says the centre has also set up surgical camps in rural areas to provide cheap and accessible care for patients. But with 88% of deliveries in Pakistan performed by unskilled birth attendants, Dr Bhutta says that progress is slow.

“There must be so many women hidden away. These are the poorest women who may not know that there is treatment. For men it is a lot easier to find another wife than seek treatment.”

Patients come from some of Pakistan’s most remote areas but also from the cities. Dr Bhutta says the centre is beginning to see quite a number of Afghan refugees.

“About seven years ago we had a patient come to us from

the most remote area of the country, the northwest frontier. She had travelled all the way after a relative agreed to help. She had fistula for a year before she made it to us and was cured. She has become the best ambassador for us in this region, and we have had women come to us after hearing about her successful surgery.”

Dr Bhutta remains concerned at the priority placed on high tech care over funding for health services for women. “I see my colleagues putting in requests for new ultrasound machines, for example, and then I see these women crowded up in the ward who want for nothing but to be free from the stench of urine. I think we are striving so hard to achieve modern gadgets, but we are still lumbered with basic problems.”

Dr Mulu Muleta, medical director at the Addis Ababa Fistula Hospital, says attitudes towards these patients have changed little over the years. “People still think women with fistula have been cursed or have an evil spirit. They are outcast from society. Fistula patients are often hidden; they don’t realise they can be treated. They are suffering in silence. Just coming to the hospital makes them feel better, as they are comforted by sharing experiences.

“The most important thing is to reach out to communities and educate them about fistula. This tragedy [of women not seeking help] is a preventable one. My hope is that one day the fistula hospital will be changed into something else and that fistula will be eradicated.” □

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A woman recovers from surgery at the Addis Ababa Fistula Hospital