south asia conference for the prevention & treatment of obstetric fistula

9-11 december 2003 • dhaka, bangladesh

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Dr. Sayeba Akhter, Professor and the Head of Gynaecology & Obstetrics Department of the Dhaka Medical College Hospital, with two of her patients awaiting repair in the fistula ward of the hospital.

COVER:
Esmithi, 22 years old, struggled for three days at home without a doctor or midwife trying to give birth to her son. Unlike most other fistula patients, Esmithi's baby was born alive and healthy, but the strain of the labour left her leaking urine. She lived with the condition for one year before she and her husband learned that treatment was available at the Dhaka Medical Hospital in Bangladesh.

Photo by Mari Tikkanen/UNFPA

contents

acknowledgements

This meeting could not have been successful without the efforts of all who have worked tirelessly, to make sure that the world does not forget that women continue to suffer from fistula. One of these individuals is Dr. Nafis Sadik, whose continued support in bringing this issue onto the global health agenda has been invaluable. We would also like to thank Dr. John Kelly, Dr. Mulu Meleta and Dr. Sher Shah Syed for sharing their technical expertise both at this conference and through their continued efforts to eradicate this condition. And we were very pleased to have the participation of partners, including EngenderHealth, WHO, and individual health care professionals. Special appreciation goes to the UNFPA Bangladesh Country Office, especially Ms.Suneeta Mukherjee and Ms. Tahera Ahmed, for hosting and organizing this conference; and to the Dhaka Medical College Hospital for hosting conference participants' visit to its fistula ward. Also, we gratefully acknowledge the presentations and active participation of UNFPA staff from the Bangladesh, India, and Nepal Country Offices, the Country Support Team in Kathmandu and the Fistula Working Group at Headquarters, including representation from TSD, IERD and the Asia and Pacific Division. And finally, we would like to specially thank Souren Teghrarian and Kate Ramsey for writing this report.

foreword

I am very pleased to present the report of the first-ever conference on obstetric fistula in South Asia. This conference has sparked important dialogue and action on the issue and is an indispensable first step towards ending fistula in the region. The conference brought together more than 50 participants from around the world including Dr. Nafis Sadik, Special Ambassador for Fistula, UNFPA staff from Bangladesh, India, Nepal and New York, officials from the Bangladesh Ministry of Health and Family Welfare, representatives from WHO and EngenderHealth, fistula surgeons and other health care professionals from Bangladesh, Ethiopia and Pakistan. The UNFPA Bangladesh Country Office hosted the conference in collaboration with the Technical Support Division (TSD) and the Asia and Pacific Division (APD) of UNFPA Headquarters in New York.

This conference marks the beginning of the Campaign to End Fistula's expansion to the South Asian region. It follows a series of similar meetings in Africa, where now 18 countries have joined the campaign. 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. There was a lively exchange of ideas by international and regional experts at the conference on the causes and consequences of obstetric fistula, strategies for its prevention and treatment and the integration of these interventions in on-going reproductive health programmes.

Some countries in the region have already begun taking steps to address the issue of fistula treatment. For instance, Bangladesh has recently completed a needs assessment of the situation, and with funds from the Islamic Development Bank, will establish the first National Fistula Centre in South Asia. In time, as a "centre of excellence," it will be able to provide for the training and research needs of the region in fistula treatment.

Women with fistula have long suffered in silence, hidden and neglected; yet they courageously continue to survive despite chronic health problems and ostracism from their families and communities. Through concerted actions in South Asia and around the world, we can prevent fistula, and for those now suffering, through treatment, we can restore hope and dignity to their lives.

Mari Simonen
Director
Technical Support Division
UNFPA

conference recommendations

1 Improve and expand interventions for prevention and treatment of obstetric fistula.

■ **PRIMARY PREVENTION:** Delaying age at first pregnancy was highlighted as an important strategy for the region, including three components:

- **Delaying age at marriage**
- **Increasing access to family planning**
- **Education of girls**

■ **SECONDARY PREVENTION:** Increasing access to a continuum of quality maternal health care services from pregnancy to delivery was urged as essential to ensuring that fistula is prevented. The following were identified as strategic intervention points:

- **Improved ANC:** Ensuring that prenatal care visits include interviews for obstetric history, screening for height/weight, and counselling for birth preparedness
- **Skilled birth attendance:** Increasing midwifery/SBA training, encouraging accurate use of the partograph, developing a protocol for management of obstructed labour, and ensuring timely referral
- **Improved access to comprehensive EmOC:** Particularly providing more in-service training for district-level doctors
- **Maternity waiting homes/transportation**
- **Treatment:** A general lack of available treatment services was acknowledged and several steps recommended for establishing quality fistula treatment care, including:
  - Identification of committed groups/individuals
  - Selection of locations for treatment services, considering accessibility (financial, geographic, cultural), type of site (freestanding/wing), centralized or decentralized
  - Provision of specialized training of personnel including physicians, nurses, ancillary medical staff, and social service personnel
  - Supportive environment for provision of services created
  - Development of a classification system and protocol for management
  - Linkages with services of excellence
  - Costing of comprehensive fistula treatment

2 Develop and disseminate messages on fistula for advocacy and awareness raising.

■ **RAISING AWARENESS:** Gaps in awareness were noted at all levels of society. Channels identified for raising awareness included media, workshops, public meetings, celebrity spokespersons, and others. The main messages identified were simple, but vital:

- Fistula exists
- Fistula can be prevented
- Treatment for fistula is available

3 Work together to identify a regional strategy for resource mobilization.

■ **DEFINING THE STRATEGY:** In order to systematically assure resource needs for the region are met, the following steps were outlined:

- Map potential donors
- Educate and sensitise donors
- Develop a clear strategy for fistula management to present to donors
- Create donor-targeted messages
- Coordinate fundraising within the region
- Identify 'new' sources of funds, e.g. zakat, private sector

4 Ensure integration of fistula related-activities with other programmes.

■ **ONGOING PROGRAMMES:** Understanding that obstetric fistula is a complex issue with many underlying medical and social issues, the following areas were noted for possible integration:

- Safe motherhood
- Family planning
- Adolescent sexual and reproductive health
- Gender/empowerment
- Human rights
- Medical education curricula

5 Conduct more research on obstetric fistula to answer identified research gaps.

■ **RESEARCH AREAS:** Lack of data is currently inhibiting regional progress in all of the above areas. The following research ideas were suggested for further exploration:

- Situation analysis at both facility and community levels
- Data collection through existing DHS, maternal mortality audits
- Establishment of a universal rate for measuring fistula
- Reproductive morbidity studies
- Evidence-based management for treatment of fistula
- Operations research
- Documentation of successful programmes
- Research on treatment controversies
- Potential student research on fistula

Next steps

Several immediate steps were identified to spark action in the region:

- **Situation analysis/needs assessments, both hospital and community based**
- **South-south cooperation: Developing a database of experts/centres 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.

A young women suffering from fistula awaiting her immininet surgical repair at the Dhaka Medical College Hospital.

highlights of the discussions

In addition to the recommendations and presentations, some relevant points were made during the discussions and are worthy of note:

Advocacy:

• In terms of the numbers involved, fistula may not be regarded as a priority; but in terms of its devastating effects, it should be a high priority.

• Community-based organizations, especially women's groups, should be tapped to raise awareness, educate the public and provide financial support to women in need of surgery.

Early and Immediate Prevention:

• Stunted growth, a result of childhood malnutrition, is an important determinant for the development of obstetric fistula. This is a particular problem in the South Asia region.

• Teen-age pregnancies in developed countries do not result in fistula. In those countries, most fistula are not obstetric – the reverse is true in developing countries.

• One reason why girls in Bangladesh are married early is to protect them from harassment in school and to preserve their 'honour'.

• Lack of anaesthetists is a major constraint to providing Caesarean sections in the region.

Treatment:

• WHO and partners are preparing a manual on the clinical management of fistula repair. In the meantime however, technical experience can be shared among specialists in different regions and countries.

• Defining success in fistula repair is difficult, as closing the fistula does not necessarily give the patient complete bladder control (stress incontinence may continue in some cases). There is also a social dimension to success, namely, social reintegration after surgery.

• For monitoring surgery outcomes, it is important to classify the different types of fistula. For some complicated types, even a 60 per cent rate of success is satisfactory.

• Fistula orientation workshops for health professionals (which took place in Bangladesh) are a good idea and can be replicated in other countries.

• Addis Ababa Fistula Hospital cannot accommodate new trainees until 2007. It was suggested to develop a database of other potential sources of training and their particular strengths.

background on obstetric fistula and the global campaign

According to a 1989 World Health Organization estimate, globally each year some 50,000-100,000 women develop obstetric fistula while giving birth. As this figure is based on women seeking treatment (the majority do not) it likely grossly underestimates the true prevalence of this condition.

In the developing world, obstetric fistula, one of the most severe pregnancy-related disabilities, is almost always the result of prolonged, obstructed labour coupled with a lack of timely access to emergency obstetric care. The condition is characterized by chronic urinary and/or faecal incontinence, resulting in both medical and social consequences for those afflicted. Obstetric fistula typically affects the most marginalized members of the population – poor, young, illiterate women in remote regions. These women lack access to maternal health services, particularly emergency obstetric care, which could prevent the fistula, and are often predisposed to obstructed labour due to malnutrition. Their young age may increase this risk, and further inhibit access to vital care.

Fistula is a devastating condition. Women and girls with fistula are unable to stay dry. They have lost their baby usually, smell of urine or faeces and are shunned by the community and, at times, even by their own husbands and families. They often remain hidden, shamed, and forgotten – and yet these women are survivors who show remarkable resilience and courage. WHO estimates that at least two million women remain untreated in developing countries, even though fistula is both preventable and treatable.

Obstetric fistula was once common throughout the world, but has been eradicated in areas such as Europe and North America through improved obstetric care. Fistula is virtually unknown in places where access to maternal health care services is near universal, women and girls are empowered to make their own health care decisions and communities are educated about reproductive health. Most fistulas can also be repaired surgically, even after several years. The cost ranges from $100-$400, but this amount is far beyond what most patients can afford. If done properly, surgical repair can have a success rate as high as 90 per cent and in most cases women can give birth again. Attentive post-operative care, for a minimum of 10-14 days, is critical to prevent infection while the surgery heals. Education and counselling are also needed to

help restore the young woman's self-esteem and allow her to reintegrate into her community once she is healed.

To raise awareness of the issue and to stimulate international action, UNFPA has launched a Global Campaign to End Fistula with a diverse array of partners including UN agencies, governments, NGOs and professional associations. Its goal is to make fistula as rare in Africa and Asia as it is in industrialized countries today.

To reach that goal, a comprehensive strategy of prevention and treatment, combined with advocacy, is pursued. This includes raising awareness at all levels – from communities to policy makers, determining needs and supporting implementation of national strategies. The goal of the strategies is simple: to prevent and treat obstetric fistula. Currently, over 20 countries worldwide have joined the Campaign and are at different stages of implementation.

After undergoing pre-operative preparations at the Dhaka Hospital, this woman is ready for her long-awaited treatment for obstetric fistula.

statement by DR. NAFIS SADIK

Undersecretary General and UNFPA Special Ambassador for Fistula

We should start by admitting that we do not know the extent or incidence of fistula in South Asia. The lack of good statistics indicates the nature of the problem: it affects the poor, the young and the female. Fistula has no priority at all on national health policy agendas. We are here to change that. We are here to declare our commitment to ending fistula.

Fistula is associated with poverty, poor medical services, and social discrimination against women. But we do not have to wait for a general increase in the standard of living, or a general improvement in maternal health services. We do not have to wait until women's age at marriage rises to conform to the law. We do not have to wait for all women to know their rights. We do not have to wait for men to understand their responsibilities towards women, especially their wives and daughters. We can start to defeat fistula, *now*.

Ending fistula may sound like an impossible hill to climb, given pervasive poverty and a general shortage of resources; given the deep-rooted structural problems found in all societies; given the inability, or reluctance, of governments to find adequate resources for health care; and given all your other responsibilities as public health officials.

But we can take heart from action against female genital cutting in many countries. There too, young women were suffering needlessly; there was a deep-rooted culture supporting the practice; there was a wall of silence around it. The sufferers were hard to reach and the societies in which they lived often felt threatened by modernization. Yet 20 countries have outlawed the practice, and it has already disappeared in many places. Change happened quickly, once the wall of silence came down, and once the alternatives became clear.

One of the keys to success in the campaign against FGC was that women themselves organized, focused and took action. Women at all levels – inside and outside the health professions, inside and outside the government, in civil society and the international community – committed themselves to the campaign. This will also be the key to defeating fistula.

As long ago as 1994, world leaders agreed to provide universal access to comprehensive reproductive health information and services by 2015. We must hold our leaders to their word.

The Global Campaign to End Fistula is a very welcome initiative from UNFPA. The involvement of EngenderHealth and other international NGOs is also very welcome.

May I wish you success in your future work.

country presentations

SOUTH ASIA: regional overview

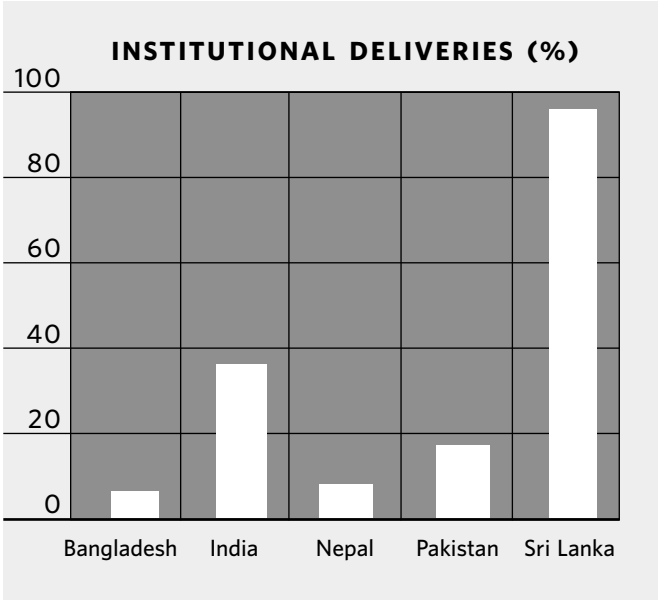
Although almost no specific data on obstetric fistula in South Asia are available, economic and reproductive health indicators suggest that what has been reported likely underestimates the extent of obstetric fistula in the region – except in Sri Lanka, the Maldives and Bhutan, which have reported no cases of fistula.

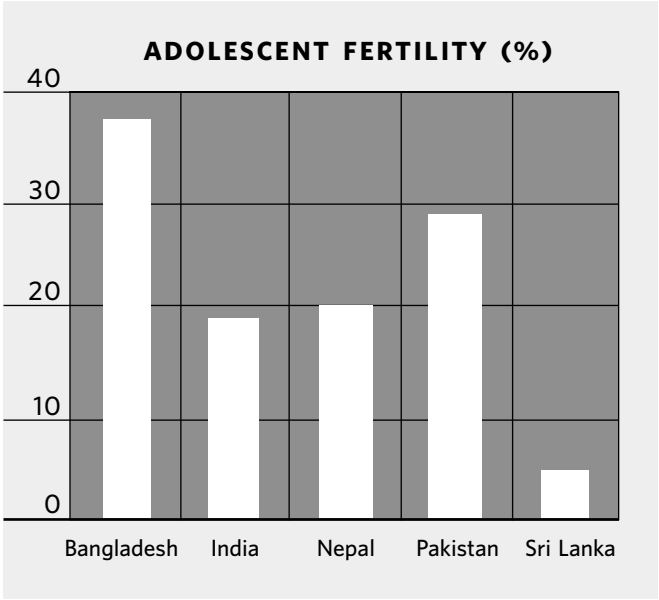
SOUTH ASIA: GENERAL INDICATORS					
	POPULATION (2003) (MILLIONS)	ANNUAL BIRTHS (1000S)[a]	GDP PER CAPITA (2001) (USD)[b]	% POPULATION BELOW $1/DAY (1990-2001)[b]	GOVERNMENT HEALTH EXPENDITURES (% OF GDP)
BANGLADESH	146.7	4192	350	36	1.4
BHUTAN	2.3	76	644	-	3.7
INDIA	1065.5	25221	462	34.7	7.5
MALDIVES	0.32	11	2082	-	10
NEPAL	25.2	817	236	37.7	4.2
PAKISTAN	153.6	5415	415	13.4	0.9
SRI LANKA	19.1	312	849	6.6	1.8

SOUTH ASIA: REPRODUCTIVE HEALTH INDICATORS						
	FEMALE LITERACY RATE (2000)	TOTAL FERTILITY RATE (2000-2005)	CONTRACEPTIVE PREVALENCE RATE (MODERN METHODS)	ANTENATAL CARE COVERAGE (%) (1995-2001)[a]	SKILLED ATTENDANCE AT BIRTH (%)	MATERNAL MORTALITY RATIO (PER 100,000 LIVE BIRTHS)
BANGLADESH	30	3.46	43	40	13	377
BHUTAN	34	5.02	19	-	15	488
INDIA	45	3.01	43	60	42	540
MALDIVES	96	5.33	32	81	90	153
NEPAL	24	4.26	35	28	12	905
PAKISTAN	28	5.08	20	43	20	476
SRI LANKA	89	2.01	44	98	94	92

SOURCE: UNFPA, *State of the World Population 2003*. Except where noted otherwise.
a. UNICEF, *The Official Summary of The State of the World's Children 2004*.
b. UNDP, *Human Development Report 2003*.

Since early pregnancy is associated with higher risk of fistula, the adolescent fertility rate in a country (coupled with low rates of institutional delivery) may provide some indication of the prevalence of this condition:





To date, only Bangladesh has undertaken a situation assessment and analysis (2003). Nepal has carried out a reproductive health morbidity survey in two districts, although it did not specifically include obstetric fistula, and has conducted an analysis based on fistula patient records in a large hospital. India has conducted community-based studies on the extent of fistula in four states and hospital-based studies on small samples of fistula patients. There have been no known studies undertaken in Pakistan.

Based on reproductive health indicators for the region as well as on patient profiles contained in facility-based surveys, contributing factors to the development of obstetric fistula have been identified as follows:

- Lack of available information concerning delivery complications
- Low social status of women, which affects autonomy in health care decision-making
- Home-based deliveries and reliance on untrained birth attendants
- Barriers to accessing emergency obstetric care; lack of transport, distance, cost
- Low educational status especially among adolescent girls
- High adolescent fertility
- Low antenatal coverage and poor quality of such care
- Malnutrition
- High unmet need for contraceptionSteps needed to address the causes of fistula include:
- Husbands, families and communities need to be educated on the importance of timely referral to appropriate facilities and plans must be in place for referral before the onset of labour.
- Policy makers need to be sensitised on the importance of skilled assistance in delivery and access to affordable, quality emergency obstetric care.
- Providers need to be trained in the use of partographs during labour.
- Communities should be mobilized (particularly women's groups) to pool resources to cover costs of transportation, treatment and rehabilitation, for those who are unable to meet these costs.

BANGLADESH: situation analysis

Almost all births in Bangladesh (92 per cent) take place at home and an estimated 64 per cent of births occur without skilled birth attendance. Caesarean sections account for 2 per cent of births. During obstructed labour, the main decision makers for seeking emergency obstetric care are mothers-in-law and husbands, whose awareness of complications is very low.

As a first attempt to investigate the fistula situation in Bangladesh, in 2003 UNFPA, EngenderHealth, local health professionals and other experts collaborated in carrying out surveys in six randomly selected communities ('unions') in six districts (also randomly chosen) to estimate fistula prevalence. Data were collected through interviews with all women who were or had ever been married. In-depth interviews were conducted with women suffering from fistula, relatives, TBAs and rural medical practitioners. In addition, in each of the six districts, the research team interviewed health professionals (especially those in departments of obstetrics and gynaecology), surgeons, and fistula patients in 6 medical college and district hospitals; these facilities were also assessed for fistula repair.

The objectives of the study were:

- To provide an estimate of women suffering from obstetric fistula
- To identify factors (social and medical) that predispose women to developing fistula
- To assess current capacity and constraints for treatment and rehabilitation
- To recommend steps necessary for prevention and care

Based on community surveys conducted in six unions (the smallest administrative unit in Bangladesh), the study found 1.69 cases of fistula per 1000 ever-married women, for an estimated total number of fistula cases in Bangladesh of 70,199. The number of ever-married women surveyed was 31,889. These figures were based on the sample studied and may not represent the actual prevalence of fistula in the country.

The survey found many fistula sufferers are abandoned or neglected by their husbands, forced out of their homes, ostracized by family and friends and even disdained by health workers, who consider them 'unclean'. Without skills to make a living, some have no choice but to beg to survive. They are so ashamed that they are reluctant to share their experiences; however, they cannot hide the smell. Women living with fistula are usually in the age group of 15-30 years, poor, illiterate and unaware that treatment is available, or cannot access or afford it.

Interviews with relatives revealed an equal lack of awareness about the consequences of early childbearing, prolonged labour and of the possibility of treatment for fistula. In one sample of 27 fistula patients, 12 had suffered from the condition for more than 10 years and 18 of them did not know how fistula could be avoided (90 per cent of patients attributed their condition to "bad luck"). Contrary to expectations, 13 of them still lived with their husbands. Most had no antenatal care and had endured prolonged labour. Among the reasons mentioned for not seeking treatment were ignorance about its availability, lack of money and lack of caregivers to be with the patient during treatment.

PROFILE OF A FISTULA PATIENT

Mrs. S. is 22 years old and has been married for 5 to 6 years. Two years after her marriage she became pregnant. She did not receive any antenatal care and her delivery was attended by a traditional birth attendant (TBA). After three days and nights of obstructed labour, she was transferred to the hospital, accompanied by a TBA. As the clinic had no facilities for performing a Caesarean section, she was taken to the TBA's home until she could be transported to the district hospital. After two days, she was taken to another hospital where a dead baby was delivered by Caesarean. After recovery, she discovered that she had developed incontinence of urine and stool (VVF and RVF respectively.) She was informed by the hospital that treatment of her condition was available at Rajshahi Medical College Hospital. She was admitted to the hospital three months after her delivery and successfully operated for her RVF. She was asked to return in three months for repair of her VVF. She could not return for her second surgery due to financial constraints. Now, after three years, she has come to be treated for the VVF.

Mrs. S. described her situation: "I have to put on heavy clothes. There are painful blisters and itching. I have to continue doing work and it causes increased dribbling of urine. Nobody wants to stay with me because of the smell. Even my husband sometimes blames me for my condition, though we have a good marital life. He has feelings for me and is not marrying again even though I have urged him to do so. We are very poor. Once I had a job, but now nobody would take me as a maid because of my problem. We have no money. My father sold his cow for my treatment." She knows another woman in her village who has been suffering from the same condition. She thinks that her urethra was somehow ruptured by the TBA. She does not know what could have prevented her present condition. (EngenderHealth: Situation Analysis of Obstetric Fistula in Bangladesh)

Data from gynaecological admissions in 2002 in six medical college hospitals were also analysed. The findings reveal that vesicovaginal fistula cases constituted up to 2 per cent of such admissions. All six hospitals studied were moderately equipped to provide fistula treatment; however, some specific supplies were not available in some of the sites, including cystoscopes, ureteric catheters, etc. Given the magnitude of the problem, the number of skilled surgeons for fistula repair appears to be insufficient. The researchers also noted an insufficient number of operating theatres and lack of anaesthetics and anaesthetists.

The district hospitals had no skilled providers for fistula treatment. Another noted constraint was the lack of available patient beds. The post-operative period for fistula cases is long and requires an average hospital stay of generally more than three weeks. As a result, preference is given to the most acute gynaecological admissions, to the detriment of fistula patients.

The hospital-based study showed that the mean age of marriage for the fistula patients was only 14.2 years and that in 88 per cent of cases their births were assisted by traditional birth attendants (TBAs). In 40 per cent of cases, delay in seeking emergency obstetric care was attributable to the patient's mother, 29 per cent to the husband and 20 per cent to the mother-in-law. As to the reasons for not seeking emergency obstetric care, the most common was ignorance of danger signs followed by high cost and ignorance of available services.

Among the observations/recommendations by the situation analysis of obstetric fistula in Bangladesh are:

- Increased utilization of antenatal care and available skilled delivery assistance
- Greater community awareness of the detrimental effects of prolonged labour
- The need to sensitise men of reproductive age, married or unmarried
- Identifying targeting areas of fistula prevalence
- Emergency obstetric services should be expanded and their availability known
- Treatment facilities for simple fistula should be available in all district hospitals
- Medical college hospitals should focus on complicated cases
- Skills training for fistula repair to gynaecologists and surgeons should be expanded
- Wards allocated specifically to fistula patients are essential to recovery
- Introduction of schemes for financial support to fistula patients seeking treatment
- Psychosocial rehabilitation after fistula surgery is essential
- Primary prevention efforts through addressing poverty, illiteracy and the low status of women in Bangladeshi society should be given priority in national plans.

NEPAL: reproductive health morbidity survey

Due to its steep mountainous terrain where half the population lives, access to health care as well as delivery of supplies to health facilities in remote areas is difficult in Nepal. According to a needs assessment conducted by UNICEF in 2000, there is 95 percent unmet need for emergency obstetric care. The maternal mortality ratio is high (539 per 100,000 live births) and more than 90 per cent of deliveries (as well as 67 per cent of maternal deaths) take place at home. Obstructed labour accounts for 16.3 per cent of maternal deaths (which is twice the global figure of 8 per cent).

Nepal is one of a handful of countries where the life expectancy of women (57 years) is less than that of men (58 years). The mean age of marriage among women is 17 years. In the absence of a comprehensive situation assessment, the few hospital-based surveys give us an interim picture of the fistula situation in Nepal.

A reproductive morbidity survey of more than 2700 patients reporting at gynaecological clinics held for several days in two district hospitals in western Nepal give a good picture of the reproductive health situation in the country with implications for obstetric fistula.

The results of the survey show that 33 per cent of the women reporting at the clinics complained of RTI/STI symptoms, 25 per cent of pelvic organ prolapse, 23 per cent of menstrual disorders, 14 per cent of infertility and 1 per cent of fistula, although fistula was not specifically included. Less than 15 per cent of the patients had basic literacy skills, 35 per cent weighed less than 45 kg and almost 60 per cent suffered from mild to moderate anaemia.

Significantly, the survey found that the number of pregnancies among women with no schooling was almost twice that of women who had attended school. The study concluded that addressing reproductive morbidity in far-western Nepal is a felt need that cannot be ignored. This calls for the provision of

gynaecological services, the training of health care workers at the district level and establishing referral links to secondary and tertiary health care facilities. The study also called for support to social development: alleviation of poverty and promotion of women's status with particular emphasis on education.

A review of hospital records of 293 fistula patients at Patan Hospital (a 300-bed district hospital near Kathmandu) found the majority in the age group 25-34 years of age. The youngest patient was 15 years old, and the oldest 72. Forty one per cent of the patients had suffered their condition for 1-5 years, 10 per cent for 6-10 years and 6 per cent for 11-20 years. The shortest duration was 2 months and the longest 52 years. More than half the cases (154) were complicated and 11 had an associated recto-vaginal fistula. The vast majority of the fistula (91 per cent) were of obstetric origin while 7 per cent were due to gynaecological surgery (hysterectomy). The success rate of the repair surgeries (first attempt) was 79 per cent and the failure rate was 13 per cent. Eight per cent were rated as cured but suffering stress incontinence. The failure rate was reduced slightly (to 10 per cent) after a second surgery.

Based on patient profiles, the reviewers observed that contributory factors to obstetric fistula are:

- Early marriage
- The status of women – social, economic and educational
- Harmful traditional beliefs and customs
- Illiteracy and lack of awareness of possible complications in childbirth
- Lack of antenatal care and negative attitudes towards hospital delivery
- Lack of roads and poor access to health care facilities
- Lack of hospitals with facilities for operative delivery and lack of trained staff.

The review concluded that surgical repair of fistula offers the only hope for women afflicted with this condition, and that such surgeries do not require sophisticated equipment or expensive medicines. As the review of cases at Patan Hospital demonstrates, they can be successfully performed in a district hospital.

INDIA: preliminary surveys

Apart from a few hospital-based studies, there are no epidemiological data on maternal morbidity or fistula in India. However, given the country's high maternal mortality ratio (436 per 100,000 live births) and its high adolescent fertility rate (almost a third of births occur to girls aged 15-19 years) it is to be expected that obstetric fistula is a significant problem in India. Adolescents make up 33.6 per cent of married women (compared to only 6.3 per cent of married males in this age group). They have a low literacy rate and one out of five are moderately or severely malnourished. The median age at first birth in India is 19.2 years.

Between the years 1989 and 1993 some community-based studies were conducted in selected sites in four states to assess the extent of obstetric fistula. The number of women surveyed were 650, 385, 803 and 3,600 in each of the four surveys with prevalence of fistula found to be 0.5 per cent, 0.5 per cent, 7.6 per cent and 0.3 per cent respectively. This would suggest that in a survey of 5,438 women,

2.22 per cent were found to suffer from fistula. However, the results of these surveys cannot be combined because they employed varying definitions and methodologies.

Between 1998 and 2003 three hospital-based studies on the prevalence, nature and causes of obstetric fistula were conducted, two in New Delhi and one in the state of Tamil Nadu. The findings are based on small samples (of less than 40 patients). The majority were below 30 years of age and a third of them developed the condition during their first delivery (in one case, the fistula occurred at her 6th delivery). Ninety three per cent developed urinary leakage within two weeks and the patients had suffered from their condition for up to 15 years. Seventy three per cent had vesico-vaginal fistula, 5 per cent recto-vaginal fistula and 5 per cent had both. Eighty four per cent of the patients had only one fistula, 13 per cent had two and one patient had four fistula openings. In the majority of cases, the fistula was attributable to obstructed labour.

Although the reduction of maternal morbidity is not a programme priority in the current UNFPA country programme in India, the country's focus on maternal mortality reduction through increased access to emergency obstetric care, skilled birth attendance, increased access to contraception, community mobilization for raising the age of marriage for girls and support for adolescent sexual and reproductive health will have a positive effect in reducing the incidence of obstetric fistula.

PAKISTAN: fistula repair camps

Pakistan has a high maternal mortality ratio (478 per 100,000 live births) and low access to antenatal care and skilled attendance at birth (28 per cent and 20 per cent respectively). Although there have been no surveys to assess the incidence or prevalence of fistula in the country, these facts, coupled with a tradition of early marriage and childbearing (particularly in rural areas) suggests that fistula morbidity is a significant health problem in Pakistan.

Dr. Shershah Syed, a gynaecological surgeon trained in the Addis Ababa Fistula Hospital, together with colleagues, has been performing fistula repair and uterine prolapse surgery in Pakistan. 679 such surgeries have been performed to date. The surgical team headed by Dr. Syed organizes "fistula camps" in different parts of the country with the aim of creating awareness regarding obstructed labour and its consequences, providing services, building local capacity at the district level and reducing stigma attached to women suffering from the condition. Eighteen such camps were held between 2000 and 2003. These services are provided to poor women free of charge. Dr. Syed also repairs fistula at a government hospital in Karachi.

Dr. Syed maintained that any doctor could be trained in surgical techniques for uncomplicated cases, which comprise the majority of cases. The procedure in most instances can be completed in 30 to 45 minutes. The next fistula camp will be set up in Kabul, Afghanistan, where the extent of fistula morbidity is not known, though according to Dr. Syed, "wherever there is war, there must be fistula."

ANNEX 1: agenda

Day 1 - Opening session
WELCOME: Suneeta Mukherjee
MEETING OBJECTIVES: Dr. France Donnay
ADDRESS BY CHIEF GUEST: Dr. Khandaker Mosharraf Hossein, Minister, MOH&FW
CLOSING REMARKS: Secretary, MOH&FW

Day 1 - Technical session 1
CHAIR: Dr. Sayeba Akhter
RAPPORTEUR: Dr. S.M. Asib Nassim
BACKGROUND ON FISTULA – Dr. France Donnay
PROGRAMMING FOR FISTULA – Dr. France Donnay (Discussion)

Day 1 - Technical session 2
CHAIR: Dr. Saramma Mathai;
RAPPORTEUR: Souren Teghrarian
Bangladesh: Overview of maternal health and fistula: Dr. Sayeba Akhter
India: Overview and hospital-based study: Dr. Dinesh Agarwal, Dr. D. Deka, Dr. Sudha Salhan
Observations of a fistula surgeon: Dr. John Kelly
Observations of a fistula surgeon: Dr. Mulu Muleta

Day 2 - Technical session 2
CHAIR: Dr. Suniti Acharya (WHO);
RAPPORTEUR: Souren Teghrarian
FACILITATOR: Tahera Ahmed
Bangladesh: Situation analysis: EngenderHealth, Bangladesh
Nepal: Overview and hospital-based study: Dr. L. N. Thakur
Pakistan: Fistula repair camps, a surgeon's observations: Dr. Shershah Syed
South Asia: A regional perspective: Dr. Saramma Mathai

Day 2 - Technical session 3
CHAIR: Dr. A.Z.M. Zahid Hossein (Head of Urology, DMCH);
RAPPORTEUR: Dr. Asib Nasim
FACILITATOR: Tahera Ahmed
Introduction to the Fistula Campaign: Advocacy and resource mobilization: Mari Tikkanen
Working groups on fistula programming:
GROUP 1: prevention; GROUP 2: treatment; GROUP 3: media & resource mobilization

Day 2 - Technical session 4
CHAIR: Dr. Nafis Sadik;
RAPPORTEUR: Souren Teghrarian
FACILITATOR: Tahera Ahmed
Reports from working groups 1, 2 & 3
Meeting of UNFPA staff

Day 3 - Concluding session
CHAIR: Suneeta Mukherjee;
RAPPORTEUR: Souren Teghrarian
Address: Dr. Nafis Sadik
Recommendations and the way forward: Kate Ramsey & Dr. France Donnay
Statement: Mr. Mizanur Rahman Sinha, State Minister of Health and Family Welfare
Closing statement and thanks: Suneeta Mukherjee

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