Beyond the Band-aid: A Holistic Approach to Obstetric Fistula

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Hadiza Soulaye was 14 years old when she became a pariah. Forcibly married to her uncle two years earlier, she had no education and little support from her family when she became pregnant a year later. Hadiza received no prenatal care, and underwent three agonising days of obstructed labour before she was taken to hospital in Niger. Tragically, her baby died and she suffered debilitating internal injuries (Kristof, 2013).

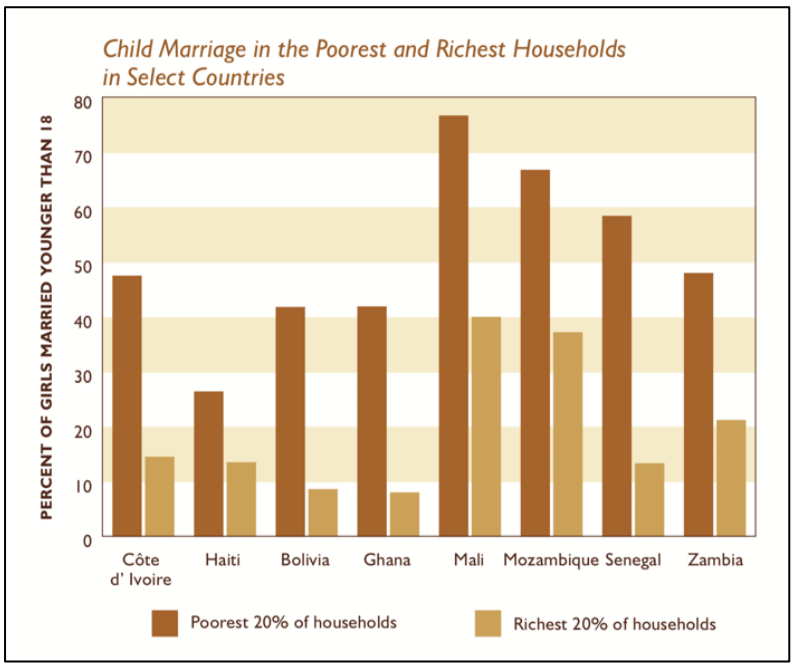
Hadiza is not alone. Each year up to 100,000 women and girls are afflicted by obstetric fistula, joining the estimated 2 million sufferers worldwide, mostly in Asia and Sub-Saharan Africa (WHO, 2018). Virtually eliminated in developed nations, obstetric fistula is a 'tragic and demoralising birth complication, affecting the world's most vulnerable' (UNFPA, 2017). The condition occurs when women are forced to labour for days without medical treatment such as a Caesarean-section, causing the baby's head to compress the blood supply to tissues along the pelvis (Tebeu *et al*., 2011). This tissue eventually dies and creates a hole, or fistula, between the vagina and the bladder, and in some instances the bowel. In over 90 percent of cases, the baby dies (Ngongo, 2022). If the mother survives the risk of infection, without treatment she will be permanently incontinent, and likely infertile (Matiwos *et al*., 2021).

More often than not, women suffer ongoing pain and social ostracisation, being unable to perform household tasks or care for children. Reduced to a life of constantly leaking urine or stool, many cultures view these women as socially inferior, or as "witches" subject to divine punishment for impurity (Nalubwama *et al*., 2020). Up to 90 percent of these women are divorced by their partners, leaving them isolated, ridiculed and forced to live on the fringes of communities where they risk dying from starvation or infection (Bomboka *et al*., 2019). Less than one percent receive treatment (Ahmed *et al.,* 2016).

The solution to obstetric fistula is often portrayed as a quick fix. In some ways this is true; a $600 surgery can repair around 90 percent of less complex fistulas (Ruder & Emasu, 2022). However, this cost is inaccessible to the vast majority of women in these circumstances, and without government funding most fistula clinics rely on donations, which struggle to cover the costs of employing surgeons let alone training local doctors. Additionally, with relatively low literacy rates, limited internet access and geographically dispersed populations, it can be very difficult to reach the women suffering – many of whom do not know the name for their condition, or that it can be treated (Drew *et al*., 2016).

In reality, obstetric fistula, and the grave socioeconomic impacts that arise from the condition, are a symptom of a much more complex, malignant problem: an intergenerational cycle of poverty, exacerbated by gender inequality. The largest risk factors for obstetric fistula are young maternal age and inadequate access to prenatal healthcare, both of which indicate deep-rooted poverty (Woldegebriel *et al.,* 2023). Most fistulas occur when the woman is a teenager – the pelvic bone does not stop growing until 21 years of age, and thus teenage mothers are more likely to suffer an obstructed labour. A narrow pelvis can also be caused by childhood malnutrition (Cowgill *et al*., 2015). As shown in figure 1, the poorer a girl is, the more likely she is to be a victim of child marriage, pregnancy, and consequently, obstetric fistula.

Figure 1: Child marriage rates by country and economic status in the year 2016



Source: ICRW, 2018

The best cure is prevention. At the macro-level, this would involve structural and long-term reform, tackling the root cause of poverty and gender inequality. Currently at least 60 percent of countries allow child marriage, and one in five countries have a lower legal marriage age for girls than boys (Sandstrom & Theodorou, 2020). Strategies such as legislation and comprehensive education programs can help reduce this, significantly improving the independence and wellbeing of millions of young women. For example, victims of child marriage are three times more likely to have received no education (World Vision, 2020). Moreover, if every girl in sub-Saharan Africa completed secondary school, there would be a 60 percent decrease in pregnancy before age 17 (Plan International, 2023).

However, these kinds of initiatives are extremely difficult to broach, requiring time, money and widespread community acceptance. The developed world tends to prioritise micro-level changes, such as small scale clinics or fundraising efforts. Although this has the potential to benefit some women, it often leads to fragmented, incohesive care for both individuals and across communities (Drakes & Kim, 2013). Coupled with an entrenched distrust for Westerners due to historic and current humanitarian crimes, implementing isolated medical practices is unlikely to support women's progress or liberation at the grand-scale. Rather, reform must take a holistic approach at the legislative level, while ensuring systemic injustices are considered and well-established practices are respected (Ayadi *et al.,* 2020). Dr Babatunde Osotimehin, former Executive Director of the United Nations Population Fund, writes:

> *'A world where women and girls need never again suffer the health, social, and economic effects of obstetric fistula is possible, especially if [the world] focuses on women and adolescents; … ensures universal and equitable access to health care, including emergency obstetric care; … and promotes government accountability for protecting human rights' (Osotimehin, 2014).*

However, this work cannot happen in isolation. Evidence shows that social stigma is the largest barrier preventing treatment, which underpins the growing understanding of the importance of community-based initiatives. Indeed, research from The University of Aberdeen's Fee Exemption for Maternal Healthcare Programme (FEMhealth), demonstrates that individual financial support is not associated with a significant increase to obstetric fistula treatment (Witter *et al*, 2016). In practice, the cure to obstetric fistula lies in identifying those who are suffering, and addressing the psychosocial barriers. Due to the substantial costs of population-wide surveys to locate fistula sufferers, local healthcare services should integrate this process alongside advancements to assessments of maternal morbidity (Baker *et al.,* 2017). Ideally, initiatives would focus their time and money on interventions such as radio campaigns to increase awareness, the training of local doctors and upscaling accessible, community health settings. For example, Dr Catherine Hamlin dedicated her career to the treatment and prevention of obstetric fistula in Ethiopia. Established in 2007, the Hamlin College of Midwives have trained and deployed over 200 midwives, who in the last year alone, have provided prenatal care to around 20,000 women, mostly from rural and remote areas (Hamlin Fistula Foundation, 2022).

By attacking the underlying sociocultural issues that perpetuate obstetric fistula at both the systemic and community level, and enhancing pre-existing healthcare structures in local areas, transformative change is possible. These approaches not only hold promise for the treatment and prevention of obstetric fistula, but promote the wellbeing, autonomy and empowerment of women and girls like Hadiza Soulaye, while contributing to the prosperity of countries and communities across the globe.

(993 words)

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