Vesico-Vaginal Fistula in Developing Countries - Time to Turn Off The Tap

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Introduction

For each maternal death, about 15 other mothers suffer significant morbidity; The World Health Organization (WHO) states that a further 20% and 50% suffer obstetric morbidity [1]. Developing countries return the highest maternal mortality figures, thus would also house majority of those with severe maternal morbidity. In a recent multicentre prospectively collected data involving 42 tertiary care centres in Nigeria, the maternal mortality Ratio (MMR) was 1088 per 100,000 live births (1.1%), maternal near-miss ratio was 15.8/1000 live births (1.6%) and severe maternal outcome ratio was 26.7/1000 live births (2.7%) [2]. Vesico-vaginal fistula (VVF) is one of such long term morbidities consequent upon poor obstetric care. VVF has remained a scourge and of public health importance not just for the attendant medical and physical disabilities but also for the inherent social, emotional and psychological strain and stress on the victims.

Current Situation

VVF is stigmatized in many populations making the true incidence and prevalence difficult to articulate. That notwithstanding, it is common in most sub Saharan countries with an estimated two million women in sub Saharan Africa and south Asia living with VVF, while 50,000 to 100,000 new cases are recorded annually as at 2008 [3], 30,000 to 130,000 in sub Saharan Africa alone [3] and about 33,000 new cases in West Africa [4,5]. In a systematic review 2013, the pooled prevalence worldwide and in different regions were documented as 0.29 per 100,000 live births (1.1%), maternal near-miss ratio was 15.8/1000 live births (1.6%) and severe maternal outcome ratio was 26.7/1000 live births (2.7%) [2]. Vesico-vaginal fistula (VVF) is one of such long term morbidities consequent upon poor obstetric care. VVF has remained a scourge and of public health importance not just for the attendant medical and physical disabilities but also for the inherent social, emotional and psychological strain and stress on the victims.

Prolonged obstructed labour remains the commonest aetiological factor in VVF in sub Saharan Africa and South Asia [10-13]. Other factors include obstetric/gynaecological operations, harmful traditional cuts and some malignancies [10-14]. The contribution of the rest pales in significance, compared with prolonged obstructed labour. Prolonged obstructed labour denotes suboptimal obstetric care and hence is rife in areas where medical health facilities are inexistent or sparse and/ or skilled personnel short in supply. This is more prevalent in the underprivileged and most vulnerable in the society, rural women, poor, ignorant and powerless. These factors also account for recurrence of VVF amongst the same population. Recurrence is further fuelled by the fact that these underserved women remain largely ignorant of the real causes of their condition and hold various misconceptions, superstitions and myths as being responsible [8,15-17]. Occasionally God or the gods as well as relatives are blamed, so also is perceived marital infidelity or past deeds [17]. Though young women having their first babies are frequently involved, grand multiparous women are not immune to the scourge [5]. The gulf of unmet contraceptive needs and suboptimal uptake of childbirth services by skilled birth attendants also do contribute significantly [5,18].

The physical toll on the victims are innumerable, prominent among which are the principal symptoms of continuous and uncontrolled urine leakage per vaginum with ensuing ammoniacal smell and dermatitis and gait impairment from obstetric palsy. The emotional toll is so grave especially if there was an associated neonatal loss. The untold psychological torture, societal and family hardship including marital separation, stigmatization and discrimination faced by them have been aptly captured, and documented by several studies cutting across the entire developing world [5,8,15,16,19]. These culminate into personal conflicts for the victims with loss of self-esteem, dignity and drive for living that some entertain suicidal thoughts. Management of such victims therefore goes beyond repair of the defect to include proper rehabilitation and re-integration into the society, empowerment and regeneration of self-worth and dignity [19,20].

Over the years invaluable efforts, programs and projects have been geared toward management of the pathology mainly skewed towards repair and rehabilitation. Primary prevention has not received equal attention. UNFPA in Nigeria in 2008 detailed a strategic framework and plan for the elimination of Obstetric fistula in that country and this addressed effectively issues of cure and prevention [21]. The targets included reduction by 80% both the incidence and prevalence of VVF by the year 2010, improve upon rehabilitation; Increase by 60% and 80% access to delivery by skilled birth attendant and emergency obstetric care (Emoc) respectively as well increasing centres offering VVF repair to 40 in the country [21]. To what extent this was achieved is not the thrust of this editorial. Rather we try to draw comparison between the cost for repair and rehabilitation and that of total prevention.

Literature is almost inexistent on the actual cost in terms of personal expenses or Governmental budgetary allocation to treat an individual with VVF holistically encompassing pre-operative management, repair, post-operative management and physical, emotional and societal rehabilitation. Citing Nigeria as an example, a country in West Africa with about 40% of VVF cases in the world [3], most cases of VVF are managed in specialized centres. UNFPA intended in 2008 to boost the number of such available centres in the country to 40 by the year 2010 [21]. One of such centres in Nigeria is located in Abakaliki in the South-eastern part of the country. The National Obstetric fistula Centre

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(NOFIC) Abakaliki was established in 2011 when the Nigerian federal government took over the South east fistula centre, earlier erected by the Wife of the Ebonyi State governor in 2008 [11]. The principal detail of the centre was to reduce the prevalence and incidence of VVF amongst the population. At intervals the centre organizes a campaign where patients of VVF are recruited and have their surgical repair free of personal expenses. Many women have benefited so far [11].

This editorial tries to project the financial and budgetary implication of such venture. One may wish to consider the financial input into the following: land acquisition, erecting a physical centre with facilities complete for admission, theatre, administration and ancillary units; recurrent budget for overhead costs and staff emolument; medical supplies and procedures including surgical repairs; patients' feeding (borne by government); facility maintenance amongst others. The unconfirmed estimated overhead cost alone at the centre is about forty million Naira ($200,000USD) annually. The total financial implication therefore may approximate two million dollars. Furthermore, there are also the financial implications of rehabilitation and re-integration into the society. Meanwhile, what financial value can one put on the emotional and psychological trauma suffered by these victims? These expenditures are necessary to improve upon the quality of life of these women and restore hope to them. They are monies well spent. But put this in better perspective, VVF is failed obstetrics. Lack of access to and utilization of good obstetric care have been implicated in almost all papers analysing epidemiological factors in VVF [8,22]. It means that with proper and safe obstetric care, majority of the fistulae especially resulting from prolonged obstructed labour would be prevented. Therefore, any single cent spent on treating fistula cases would have been saved and ploughed into strengthening the health system.

What Next?

The analogy is always drawn with flooding at home caused by an opened water tap, mopping the floor is considered treatment, whilst the water continues to flow out, the floor will never get dry; but turn off the tap (prevention) and mop, and one has a dry living room. In VVF, it is now time to turn off the tap. Aetiological factors have been traced to individual, community, society and governmental factors. And turning off the tap will imply actions at and on each of these levels.

At the individual level, ignorance seems to drive the whole pathology. Ignorance breeds poverty, unnecessary submissiveness to the male in reproductive health matters, poor health seeking behaviour and wrong perception of the causes of VVF. On a long term, girl child education will serve to eradicate all the problems emanating from ignorance. An educated woman understands the need to seek for health care at the right places, understands causes of common pathology, would unlikely be involved in early marriages and harmful traditional practices. Investing in girl child education not only kick-starts positive living for the child and builds her holistically for life but also protects her against the negative influence and consequences of ignorance, enhances her economic societal worth, hence empowering her to take responsible reproductive health decisions, including accessing health care, family planning services, prenatal and delivery services under skilled care. These Measures prevent VVF. In the short term, massive health awareness campaign to educate the population on the need to utilize existing health care facilities in their locality and address misconceptions regarding health issues result in uptake of prenatal, delivery and emergency obstetric care by concerned individuals.

At the family and societal level, misconception, superstitions and myths still characterize interpretations giving to health issues; stigmatization and discrimination against VVF remain rife; cultural and traditional harmful practices like early marriages, genital cutting, unequal educational opportunities for the girl child and male dominance continue to drive gender inequity. These promote maternal morbidity including VVF, drives VVF victims aground and hence preserving the already high prevalence of the condition. Massive awareness campaign and advocacy can ameliorate this situation and drive positive societal changes especially in terms of cultural and traditional changes and perception of maternal health issues. The family and community can now be the platform for positive health changes which affect the woman's decisions and behaviour for better health seeking outcome. Funds expended in awareness campaigns to identify victims [11] can be ploughed into this campaign with a better outcome. Prevention rather than cure. If there is no case there would be no victim.

Obstructed labour can be entirely preventable when labour is managed by skilled birth attendants. Access to quality obstetric care including emergency obstetric services can be enhanced by government, non-governmental organizations and individuals involved in health care delivery. Health facilities should be sited in both rural and urban areas complete with essential equipment, medical supplies and personnel. Health system, referral services, transportation and communication need be improved upon. If money spent on erection and sustenance of dedicated centres for management of VVF can be channelled to strengthening existing and new health facilities equally distributed, VVF may be a thing of the past especially with trained manpower that can manage each labour with the partograph and offer emergency obstetric care when applicable. This also can improve all other health indices in the population and not VVF alone. Nevertheless, in the rural areas of developing countries where paucity of infrastructure creates uncomfortable environment for specialist health workers, incentives can be added to basic emoluments to ensure their presence and continued function in the rural centres. At the National level, brain drain of trained health personnel to western countries of Europe and America should be truncated [20].

Conclusion

Government and non-governmental organizations including WHO and United Nations agencies have over the years in recent past championed and continue to champion the treatment and rehabilitation as well as preventive measures of VVF victims in developing countries. However, the skew tilts towards treatment rather than prevention as underscored by continuing diagnoses of tens of thousands of new cases annually [5]. It implies that the humongous funds and resources [23] and human effort invested so far have not yielded the much desired result; the water tap is still open. It is time therefore that the tap is turned off. Turning the tap off involves actions at the individual, family, community and governmental levels. Let the efforts and funds be skewed towards prevention while efforts to mop up existing cases continue. This is moreso, when viewed as a matter of fundamental human rights for women, drawing from United Nations Universal declaration of Human rights to which almost all countries are signatory, as well as other charters including the Maputo protocol [24-26]. As 2015 rolls by and the targets set for the Millennium development goal 5 (MDG 5), yet to be achieved, preventing VVF must be factored in in the post 2015 agenda of developing and developed countries alike. It is a human rights issue. Actions and campaigns aimed at prevention would surely be cheaper and more cost effective than the current programs aimed at repair and rehabilitation.

References


