Sexual activities in ethiopia health and social care essay

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Review article

CAUSES AND CONSEQUENCES OF OBSTETRIC FISTULA IN ETHIOPIA: A LITERATURE REVIEW

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ABSTRACT

Obstetric fistula (OF) is one of the major potential complications of childbirth mostly young women in developing countries including Ethiopia. Though few scientific studies have been conducted related to its causes and consequences, it is challenging to find a comprehensive figure about obstetric fistula in Ethiopia. Therefore, this paper sought that to review the causes and consequences of obstetric fistula in Ethiopia. A number of relevant obstetrics and gynaecology websites and journals were reviewed. Google, Pubmed, and Hinari searching engines were used to find out relevant references. Year of publication, location, language and its type of publication were the inclusion criteria used for reviewing literature. It is observed that obstetric fistula has been a major burdened mainly for women in the rural Ethiopian and its causes and consequences are very deep and diverse. The great majority of obstetric fistula causes in Ethiopia is due to Obstetric labour. Distance to the health care facility, transportation access, economic factors (poverty), poor knowledge related to the problem, poor health seeking behaviour of the affected women and age at first marriage are the other triggering factors. Stigma and discrimination of obstetric fistula

patients by their husbands and families, economic dependency and psychological disorder are often mentioned as consequences for OF patients in Ethiopia. Keywords:

INTRODUCTION

Each year pregnancy related complications claim the lives of over 500, 000 women worldwide with about 99% of these deaths occurring in developing countries 1. Current estimates indicate that for each woman who dies from pregnancy related complications, another 15 to 30 suffer serious morbidities, and all these are preventable and treatable conditions 2. With the current maternal mortality ratio of 676/100, 000 and annual deaths of 25, 000, Ethiopia is a major contributor to the worldwide death toll of mothers 3, and it is estimated that each year more than 500, 000 Ethiopian women and girls develop disabilities from complications during pregnancy and childbirth 4. Obstetric fistula (OF) is one of the major potential complications of childbirth, causing misery to many, mostly young women in developing countries. It is an abnormal connection between the vagina and bladder (vesico vaginal fistula) and/or the rectum (recto vaginal fistula), resulting in uncontrollable leakage of urine and/or stool and often resulting from prolonged obstructed labour. The constant pressure of the fetal presenting part against the soft tissues around the vagina and bladder and/or rectum causes ischemic necrosis, leaving a hole behind with leakage occurring after 3-5 days and the extent of injury depends on the duration of labour 5. Approximately 2-3. 5 million women may be living with fistula worldwide, with 50, 000-100, 000 new cases occurring annually, most of which are in the Sub- Saharan Africa and Asia5, 6. Though, the exact prevalence not well known in Ethiopia it is

believed that between 26, 000 and 40, 000 of women with OF live in Ethiopia 4. In an unpublished national survey by the Addis Ababa Hamlin Fistula Hospital (Prevalence of Obstetric Fistula in Rural Ethiopia 2005), it is estimated that the incidence of OF in rural Ethiopia was found to be 2. 2 per 1000 women of reproductive age 4 and also 9, 000 of new cases occur every year in Ethiopia, of which only 1200 are surgically repaired 6, 7. A woman's obstetric history is the most salient element in the development of an obstetric fistula. It is often stated that fistula patients tend to be young women with small, immature pelvis (most commonly primiparas), with an antecedent history of obstructed labour, prolonged delay in receiving emergency obstetric care, sometimes having undergone late caesarean delivery. Age, parity, duration of labour, the place of delivery, and whether the delivery was attended by a qualified person along with the proportion of caesarean sections are the most important socio-medical factors in the development of fistulas 3, 6, 8. Obstructed labour is primarily responsible for obstetric fistula. It occurs in about 5% of pregnancies and accounts for 8% of maternal deaths 9. The vast majority of OF cases live in resource-poor countries, and almost all of these injuries could have been avoided if timely and competent obstetric care was available, accessible, and affordable 9. In resource limited settings, the development of OF generally linked with the three delays in care seeking, transportation, and in getting the services at the facility. Avoiding the three stages of delay can substantially reduce the risks of prolonged obstructed labour and thus of obstetric fistula. In Particularly, lack of knowledge to recognize pregnancy and labour complications; powerlessness to seek care; distance from facilities; lack of transport and poor roads; unavoidable costs of transport and health services;

and low expectations of the care they deserve, serious shortages of medical supplies and equipments, theatre space, and particularly trained personnel, further undermine the timeliness and quality of the care they receive. As a result, they often remain sufferers for years or decades 9, 10. Fistula can also be of non-obstetric cause: laceration, rape and other sexual trauma such as sexual violence. Mostly, poverty lies behind the occurrence of most fistulas. Early childbearing increases the risk, too. Because of poverty most girls are malnourished and stunted since their childhood. So, they will have underdeveloped skeleton and pelvis where the labour will be obstructed during delivery leading to fistula 8, 10, 11. The immediate consequences of such damage are urinary incontinence, fecal incontinence, and excoriation of the vulva from the constant leakage of urine and feces. Other problems include anaemia, foot drop, contractures at the knee or hip joints, and depression. The most common fetal outcome is still birth and rarely suicidal may be committed due to social segregation and depression 4. The bad odour arising from incontinence often results in negative social consequences, including divorce and ostracization from society. The existing data suggest that large numbers of women with OF become divorced or separated from their husbands, particularly when it becomes evident that their condition is more chronic rather than transient. Successful repair of the fistula is assumed to lead to a smooth reintegration when these women return home; however, they may still face problems reintegrating into their local communities though it is not well investigated and documented so far. Simply repairing the injuries is not the end of the challenge 4.

Access to primary health care service, Fertility trends and Sexual activities in Ethiopia

About 86. 7% of the general population in Ethiopia have access to primary health care services 12; low access to safe motherhood service (37%) and obstetric care service also very low which is 54 out of 100 13. The legal age of marriage in Ethiopia is 18 years for both males and females, but it is widely ignored and it takes place in earlier ages. The median age at first marriage among women age 25-49 is 16. 5 years. The proportion of women married by age 15 is 8 % among women currently age 15-19. About 10% of the total fertility rate in Ethiopia derives from births to women aged between 15 and 19 years 3. The Ethiopian demographic health survey (2011) also indicated that among women age 25-49, 29 percent first had sexual intercourse before age 15, 62 percent before age 18. The median age at first sexual intercourse for women age 25-49 years is 16. 6 years, which is very close to the median age at first marriage of 16. 5 years. This suggests that Ethiopian women generally begin sexual intercourse at the time of their first marriage 3. Despite the relatively better primary health service coverage available (86. 7%), the health service utilization rate is very low (32%) in Ethiopia (12). Hence, the country has one of the lowest antenatal cares (34%), postnatal care (7%), and institutional delivery care (10%) though progressively increasing every year 3. Though limited studies have been conducted so far in regards the causes and consequences of Obstetric fistula (OF) in Ethiopia, there are some papers that try to reveal the tip of iceberg in related to the problem. Therefore, this paper sought that to review the causes and consequences (social, economic and psychological) of obstetric fistula in Ethiopia.

METHODS

A number of relevant obstetrics and gynaecology websites and journals were reviewed. The following searching terms in different combination were also used: obstetric fistula, causes, social, economical, consequences. It was reviewed both qualitative and quantitative data to gather evidence on cause and consequence of obstetric fistula from different articles. Google, Pubmed, and Hinari searching engines were used to find out relevant references. FMOH and WHO reports also used for this particular review. Year, location, language and its type of publication were the inclusion criteria used for reviewing literature. Studies conducted in the last one decade; since 2000 G. C, only studies conducted in Ethiopia and published in English language, and pre-reviewed studies, guidelines and official documents addressing causes and consequences of obstetric fistula were considered in this review. However, studies not fulfilling these inclusion criteria??? s were excluded to be reviewed.

Findings

For a better description, the following two themes were identified: causes of Obstetric fistula and Social, economic and psychological consequence of Obstetric fistula in Ethiopian.

Causes of obstetric fistula in Ethiopia; Patient characteristics and Access to services

An epidemiological study conducted among treated cases of OF at Addis Ababa Fistula Hospital (AAFH) indicates that 97. 4% of the cases were caused by obstructed labour out of which 63% of them were during their first birth (10). Biruk et al. also indicates that 95. 4% of the fistulae were caused

by childbirth; coitus, surgery, trauma and others constitute only less than five percent of the cases 14. Another study conducted in the Addis Ababa Fistula Hospital (AAFH) indicates that the most important causes for not reaching a health institute during labour are distance, economical factors and poor knowledge in 28. 2%, 13. 6% and 9. 8% of the cases, respectively 15. More than 99% of patients taking treatment in AAFH are illiterate 16. Likewise, Kelli J. was conducted a record review assessment of 309 patients performed vesicovaginal operations in AAFH showed that the women were of average age 22. 4 years in the range of 9-45 years and 82% of them travelled at least 700 kilometres for treatment, walking an average of twelve hours and spending an average of 34 hours in a bus 17. Emergency transport access is a serious concern (due to poverty) in Ethiopia, in a survey of patients at AAFH found that on average, it takes women in labour 11 hours to reach a health care facility capable of addressing their needs. Women in labour can spend several hours travelling on a makeshift stretcher over difficult terrain which can induce other health complications for the mother. Where access to roads is available, delays of several days due to the difficulty in identifying the danger sign are often encountered as families try to raise the money necessary to pay for hiring a vehicle to transport the patient. Emergency transport costs are an overwhelming financial burden for families. In more remote areas, emergency access costs can easily rise to thousands of birr for transport of a single patient and accompanying family members. The delays in access to health services caused by the difficulties in raising such sums of money are one of the important contributors to the occurrence of obstetric fistula in Ethiopia and subsequently increased vulnerability in the country 18. In depth epidemiological analysis of OF from

the data gathered for EDHS, 2005 by Yibeltal T. showed that more than 3. 4% of the respondents were experienced obstetric fistula and surprisingly 70% of them also not treated by the time of data collection. The study also indicated that the development of OF was different along with their marital status; women who were widowed or divorced or separated were the most affected by OF (6. 5%) followed by then currently-married women (4. 0%) and the never-married ones were the least affected (0. 9%). There was also a statistically significant association between marital status and experience of obstetric fistula (p-value <0. 001). According to this study, women with total children ever born of 5 or more (5. 8%) are more affected by OF compared to those with total children ever born of 1-4 (3. 9%) and zero (0. 9%) (9). The other study conducted by Muleta M. in AAFH indicated that about 94% of fistula patients were married and 83. 6% had been through with the delivery caused the fistula before the age of 20. 19In Ethiopia, the prevalence of OF across the region was different. Yibeltal T. found that the highest prevalence was recorded in Afar region where about 6 % of women had experienced OF followed by Somali region which was 5. 7%. The lowest prevalence of OF was recorded in Addis Ababa (1. 2%). This study also noted that Orthodox Christians (2. 5%) were the least affected compared to Protestant (4. 2%) and Muslims (5. 3%) 9. In Ethiopia, there is also a marked difference in the level of prevalence of obstetric fistula between urban and rural areas whereby OF is more common in rural areas (4. 5%) than 1. 7% of urban areas. In urban areas, the highest (4. 3%) and the lowest (0. 4%) prevalence of OF were recorded for women of age groups 35-39, and 15-19 and 25-29 respectively. For rural cases, the lowest prevalence (2. 7%) was observed for women of age groups 30-34. In both the urban and rural cases, higher OF

prevalence, more than 4% were recorded for the older age groups i. e., more than 35 years with the highest record being for rural women of age group 40-44 years (8. 7%) 9. Obstetric fistula is highly prevalent among rural women with less than 18 years of age at first marriage (5. 3%) and urban women with less than 18 years of age at first birth (5. 9%). Unlike the urban places, the prevalence of obstetric fistula was yet higher among rural women of 18 years or more of age at first marriage (4. 5%) and age at first birth (5. 2%) respectively. Tebekaw Y indicated that women who give birth before 18 years of age are more affected by OF than those who marry at that same age 9. While most cases stems from obstetric causes, others result from direct trauma caused by rape or other sexual abuses. Muleta M and William G. noted that at the Addis Ababa fistula hospital, 91 of 7, 200 cases over a six-year period, or about 1. 2%, were caused by rape or other sexual abuse 20

Social, Economic and Psychological Consequences of Obstetric Fistula in Ethiopia

Obstetric Fistula (OF) can have terrible social consequences: The physical consequences of fistula including the continuous leaking of urine, faeces, or both and the resulting odour usually make a normal life difficult. Fistula patients are often shunned, abandoned, or divorced. More than 50% of the women were rejected by their husbands after the fistulae developed, leaving them without means 19. In AAFH, for example, 53% of the women had been abandoned by their husband and one out of five of them have to beg for food to survive 21, 22. An in-depth interview conducted in rural Ethiopia shows that; one untreated women with OF said that ??? My husband hated me and

labelled me as dirty, it has been long time when we slept to gather???. This study also revealed that among 50 obstetric fistula patients who are continuing to live in the same house as their families 10 of them were not allowed to eat with family members together 4. Low self-esteem, feelings of rejection, depression stress, anxiety, loss of libido and loss of sexual pleasure were commonly reported by women with fistula. It also appears that the rates of separation or divorce increases the longer a woman lives with a fistula particularly if she remains childless. Not surprisingly, successful fistula repair reduces the prevalence of these psychosocial pathologies 8. WHO has estimated that the rate of social exclusion in Ethiopia is 53% 22. Other articles document the presence of these social problems in women with fistulas. Muleta et al reported 69. 2% of fistula victims were divorced, only 19. 2% were members of a local community association, and 44. 2% ate separately from other family members. Forty-eight of 52 women felt listless and 28 had suicidal thoughts 21. Goh et al. conducted a prospective observational study to screen women in Ethiopia with fistulas for mental health dysfunction, this study showed that of the 68 women with fistulas screened, 66 were at risk for mental dysfunction as measured by the General Health Questionnaire compared with only 9 of 28 controls. In a prospective interventional study, 51 women with fistulas in the north of Ethiopia were screened for mental health issues before and 2 weeks after surgery 23. Though OF have deep social and psychological consequences, it could be avoided if women could delay childbearing until after adolescence, if skilled attendants could monitor all labours and if women could have timely access to good emergency obstetric care. Moreover, most women who develop fistulas could be treated surgically to have the damage repaired. Therefore,

the government of Ethiopia has been done different intervention to improve the situation and to fight against fistula such as fistula treatment hospitals (AAFH and its branch hospitals in different regions) has been increased in number for identification of fistula cases for treatment and etc, there has been also improvement in age at marriage in the last decades, efforts to increase skilled delivery, road infrastructures and ambulance services at district level also give emphasis in the health sector development plan.

CONCLUSION

In conclusion, OF have been a major burdened mainly for women in the rural Ethiopian and its causes and consequences are very deep and diverse. The great majority of OF causes in Ethiopia is due to Obstetric labour. Various factors are contributing that still the problem is getting high public health significance: Distance to the health care facility, transportation access, economic factors (poverty), poor knowledge related to the problem (Illiteracy level), poor health seeking behaviour of the affected women and age at first marriage are the most important factors that contributed to the high prevalence of Obstetric fistula. Other socio demographic factors also found to be a factor for the experience of OF such as marital status, residency area (Urban Vs Rural). The prevalence of OF also differs across the regions in the country; the most marginalized regions such as Afar and Somali are more affected. Social consequences such as stigma and discrimination of OF patients by their husbands and families, economic dependency (begging for food to survive), and psychological disorder (mental disfunction and suicidal thoughts) due to these deep social and economic burden of the problem are often mentioned consequences for OF patients in Ethiopia.