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End the suffering of women with obstetric fistula and pelvic organ prolapse in post conflict settings of Tigray region, northern Ethiopia

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Editorial

Fistula is defined as “a hole or an abnormal opening” between human vagina and rectum and/or bladder through which her urine and/or feces continually leak resulting from inadequately managed or prolonged obstructed labor [1,2]. Pelvic Organ Prolapse (POP) is the herniation of a pelvic organ into or outside of the vaginal canal which results from weakness or injury of the pelvic floor supports results to advanced age, multi-parity, carrying heavy loads, and deterioration of the pelvic floor connective tissue/collagen [3]. Both are debilitating maternal morbidities and greatly affect women’s quality of life through expressively compromising their physical, social, psychological, sexual and economic functions [4]. Estimates indicate that above two million women suffer from undetected or untreated fistula globally, and that 50,000 to 100,000 new cases occur each year [1]. In Ethiopia, approximately 36–39,000 women live with this disability with an additional 3500 new cases annually [5]. Likewise, POP occurs in about 316 million women in the world [6].

There are a number of complex factors that contribute to the three delays model that exacerbates the burden of POP and OF: delay in seeking treatment, delay in arriving at a health-care facility; and delays in receiving appropriate, high-quality care once at the facility [7]. Moreover, the number of obstetric fistula survivors who have not received treatment is still too high—nearly 142,387 cases [8]. The rate of prompt treatment seeking is typically low, and the treatments that are offered are not fully utilized. Apart from the painful consequences of a sharply increased incidence of fistula, war causes significant devastation of health facilities and the collapse of the entire health system. In effect, case identification, referral linkage, treatment and reintegration services for OF cases would be severely compromised [9].This dooms, those women to experience very difficult and long labor that exposes them to give birth at home or bushes without any skilled health professional assistance. Besides, lack of security and financial constraint to cover transport costs impede victims’ self-initiated mobility to functional centers for seeking treatment [9]. Because of this, the number of women who had OF increased significantly throughout the war, from 1.4/1000 live-births, in the pre-war period to 12/1000 live-births, it includes both suspected and conformed cases in the post-war period. Comparatively, between the pre- and post-war periods, the POP increased from 12/1000 to 37/1000 women includes both suspected and confirmed cases [10,11].

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Despite, a number of worthwhile initiatives have been made to include OF in the global health agenda and further its eradication, the progress is gradual [12]. Also, a great deal of misery befalls POP-affected women because a large number of them choose not to seek medical attention despite the disease's ongoing terrible ravaging of their quality of life [13]. Additionally, it affects more women than OF and receives minimal treatment support from donors and it is not designated as a maternal health indicator in the country's demographic and health survey. Thus, this editorial calls for collaborative efforts to end the suffering of women from such a morbidity by focusing on the prevention, correcting communities' misconceptions about the causes, and changing their attitude towards the survivors, decentralize the service to the periphery, capacitating the knowledge and skill of health professionals, device an active case finding at the grassroots level and apply a find and treat approach. Improvements to maternal healthcare system which focus on reducing the three delays will have the greatest impact in reducing maternal morbidity and mortality in Tigray region, northern Ethiopia.

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