Re: 'Delivery mode for prolonged obstructed labour resulting in obstetric fistula: a retrospective review of 4396 women in Central and East Africa'. (First comment on BJOG-19-1192.R1)

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Letter to the Editor, BJOG Exchange

Re: Delivery mode for prolonged obstructed labour resulting in obstetric fistula: a retrospective review of 4396 women in Central and East Africa

In their paper 'Delivery mode for prolonged obstructed labour resulting in obstetric fistula: a retrospective review of 4396 women in Central and East Africa'[1] Ngongo et al make the point that 84% were delivered of a stillbirth and that there was a rising trend in caesarean delivery rising from 45% to 64% in the 14 year study period. This is mirrored in a recent study by Tasnin[2] et al who in a cohort of 634 women reported that 58% of the fistulae they were seeing were iatrogenic, rising from 43% in 2007-7 to 71% 2017-18, a significant number resulting from hysterectomy. A study from Hamlin Fistula Ethiopia[3] looking at all new fistula presenting to 3 of their facilities between 2011-2015 showed that the number of new cases fell year on year by 20% but the percentage of iatrogenic fistulae rose from 26-32%.

It is worth examining the possible reasons for this apparent rise in iatrogenic fistulae. Millennium development goal number 5 was to reduce maternal mortality and improve maternal health. Countries with a high maternal mortality ratio tried to increase the number of women delivering in an institution with a skilled birth attendant who could identify the onset of obstruction by the use of partograms and detect a deterioration in the maternal and fetal condition, hopefully ensuring proper management in the most suitable setting. . To this end hospital practitioners, in Ethiopia health officers with surgical training, were taught caesarean section, and newly qualified doctors had to spend time in rural health facilities. They were required to undertake caesarean section with little training other than limited practice in carrying out elective caesarean section under supervision in a regional facility. Importantly they have little training in how to place incisions appropriately when the fetal head is deeply engaged and in safe techniques to dis-impact the head. Even basic care such as ensuring the bladder is empty, and continuous drainage post-delivery may be ignored. This pattern is repeated in most Sub-Saharan countries and those that have limited access to medical care. Practitioners would have had little if any training in operative vaginal delivery and would be very unlikely to have carried out a destructive delivery. Those of us working in fistula surgery have also noticed an increasing number of women presenting with severe perineal and urethral (leading to loss of the distal urethra) trauma which has not been treated or poorly treated at the time as the necessary expertise or equipment has not been available. Health professionals are reluctant to take responsibility, blaming a failing service and mothers who do not seek help early.

Dealing with these problems in rural areas with poor transport is difficult. Medical professionals in rural areas with their lack of facilities, long hours if not weeks of duty, and associated poor pay are not attractive for either the professionals or their families, many of whom will stay in urban centres isolating the doctor

further. These problems are difficult to resolve but need to be tackled if one is going to improve maternal outcomes in a low- income setting. There are no easy solutions but better audit, possibly performance related pay and a greater personal responsibility for the care provided may be a start to improve the care for the many thousands of poorly provided for mothers.

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1. Ngongo CJ, Raassen TJIP, Lombard L, van Roosmalen J, Weyers S, Temmerman M. Delivery mode for prolonged, obstructed labour resulting in obstetric fistula: a retrospective review of 4396 women in East and Central Africa. BJOG 2020; https://doi.org/10.1111/1471-0528.16047.
2. Tasnin N, Bangash K, Amin O, Luqmen S, Hina H Rising trends in iatrogenic urogenital fistula: A new challenge.

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