To the Office of the United Nations High Commissioner for Human Rights

Report of
COMITATO COLLABORAZIONE MEDICA
on preventable maternal mortality and morbidity and human rights:
Obstetric Fistula

Almost two million women in the world are suffering from fistula and at least between 50,000 and 100,000 new cases are reported every year. The problem affects the most marginalized members of society: young, poor and illiterate women. Prevalent in Africa, south Asia, Oceania, Latin America & Middle East, with 80-90% of cases in Africa, mostly in Sub-Saharan Africa. Particularly high rates are reported in Nigeria, Ethiopia, Sudan and Chad.

Obstetric fistula is an injury of childbearing constituted by a hole or tear in the tissue wall between the vagina and either the bladder (VVF) or the rectum (RVF), or holes between both of them, that brings as result incontinence of urine or/and faeces.

Although substantial numbers of fistulas are caused by trauma, by sexual abuse or coital injury in child brides, by infection, and by harmful traditional practices, its most common cause is obstructed labour. During the obstructed labour the soft tissues of the pregnant woman’s vagina, bladder, and rectum are compressed between the foetal head and the maternal pelvic bones by the uterus’ contractions. As the foetal head is forced into the pelvis, the blood supply to the mother’s soft tissues is progressively constricted until being completely shut off. In almost every case the child dies and few days after the labour a slough of necrotic tissue comes away, leaving a fistula in its place.

Because of the incontinence resulting from fistula, women are marginalized by the society, often abandoned by their husbands and cast out by their families; moreover as the cause of the condition is not readily apparent to the community, that may view this condition as form of divine punishment or as a form of venereal disease, women affected by it are isolated. Furthermore about 20% of affected women develop foot drop, which adds further “disability” to the condition, and makes more difficult to be self sufficient for abandoned women.

5 See supra L. L. Wall, no. 4, p. 1205.
6 See supra The second meeting, no. 15.
Causes

The causes of fistula are different and interlinked between themselves. Poverty and its association with early marriage and malnutrition are one of the main factors. In fact, poverty reduces the opportunity of access to adequate obstetric care as well as malnutrition and childbearing at young age, namely before the pelvis is fully developed, contribute to obstructed labour and consequently to fistula.

1. Access to health care services
   The lack of skilled attendance at birth, the lack of emergency obstetric care, limited awareness of the personnel about the problem\(^7\), the lack of medication, difficult access to hospitals in certain areas are all factors related to care services that influence the high prevalence of both maternal mortality and obstetric fistula.
   In particular in relation to prevention of maternal mortality and obstetric fistulas, emergency obstetric care (EmOC) should be widely available\(^8\). This system could drastically reduce the cases of obstructed labour and according the UN Guidelines, it should be available at least in one facility per 500,000 people\(^9\). EmOC, in order to relief obstructed labour, includes caesarean section, that requires instruments and personnel that sometimes are not available in the medical facilities.
   Obstetric fistulas could be prevented by adequate intrapartum care that would diagnose the abnormal progression of labour and would allow timely intervention before labour became obstructed\(^10\). In practice it affects women in developing countries, and the reality is that one out of four women is still giving birth without any professional assistance\(^11\).

2. Early marriage
   Young women, although ready to conceive do not have a well developed pelvis to allow the child to pass without consequences\(^12\). It is important to point out that the problem does not affect only young women, but can affect women of every age; however the average age of fistula patients is below 25 years old, and many are as young as 13 or 14 years\(^13\).

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7 See supra The second meeting....., no. 15.
10 See supra L. L. Wall, no. 4, p. 1206.
13 See supra L.L. Wall, no. 4, p. 1206.
A women’s right to choose if, when and whom to marry is a fundamental human right, secured by the provisions of a number of international human rights instruments. The Committee on the Elimination of All Forms of Discrimination Against Women (CEDAW) in its General Recommendation no. 21 concluded that “the minimum age for marriage should be 18 years.” This idea has been pursued by other General Recommendations from the same Committee, by General Comments from the Committee on Economic Social and Cultural Rights (CESCR), the Human Rights Committee (HRC), and the Committee on the Rights of the Child (CRC). While most countries report that national laws comply with the international instruments, custom and tradition in reality contravene them, and the laws on minimum age of marriage are not enforced.

3. Malnourishment

Malnourishment hinders pelvic growth, and in many countries women are more affected by lack of food than men. In areas where the food is already scarce, family feeding patterns often discriminate against women, leaving them last to be fed. Malnourishment hinders their pelvis growth, constituting one of the causes of obstructed labour, that can cause maternal mortality and obstetric fistula. Art. 11 (1) of the International Covenant on Economic, Social and Cultural Rights (ICESCR) requires States to take measures to ensure “the right of everyone to an adequate standard of living […] including adequate food.”

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19 See supra GR 21 CEDAW, no. 32, par. 15.


21 See supra R.J. Cook, B.M. Dickens, S. Syed, no. 14, p. 73.

22 See supra ICESCR, no. 31, art. 11 (1).
The so-called right to food is linked to the dignity of a person and it is indispensable for the fulfilment of other human rights\textsuperscript{23}. The CESCR considers that one of the “core obligations” of every State is to ensure to everyone the access to the minimum essential food\textsuperscript{24}. Moreover the HRC considers the right to food as an essential component of the right to life, stressing the obligation upon States to eliminate malnutrition\textsuperscript{25}. Women should be ensured an adequate nourishment in order to develop their pelvis in a way to give birth diminishing the risk of obstructed labour. The fact that women are left the last to be fed must be seen as discrimination against them, and this is an infringement of the ICESCR\textsuperscript{26}. States are requested to address any traditional practice not allowing women to eat until men are fully fed\textsuperscript{27}. Moreover in order to fully realize women’s right to health, States have “to respect, protect, and promote [their] right to nutritional well-being”\textsuperscript{28}. Therefore States can be held accountable if they do not ensure the right to food, and if they do not refrain from any kind of discrimination against women in access to the nourishment they need to grow and develop in a healthy way.

\textbf{Prevention}

The education should focus primarily on girls in order to make them aware of sexual and reproductive health, and it should involve the whole community as well, in order to eradicate false believe surrounding obstetric fistula, and aiming to eradicate discrimination toward women suffering because of the condition. It is important the role sexual and reproductive health education can play in order to avoid false beliefs and to give children correct information about it.

\textbf{Treatment}

Obstetric fistula is treatable through a surgical reconstruction that costs between 300\textsuperscript{29} and 350\textsuperscript{30} US Dollars. The operation is more successful whether done three months after the labour\textsuperscript{31}. The reconstruction has been proven to be successful in 88 – 93\% of first time cases\textsuperscript{32}. If a women presents within three months after injury, prompt initiation of continuous bladder drainage with a catheter can allow spontaneous closure of the fistula, particularly if it is small\textsuperscript{33}.

\begin{itemize}
\item \textsuperscript{24} See supra GC 14, no. 34, par. 43 (b).
\item \textsuperscript{25} General Comment no. 6 Human Rights Committee, http://www.unhchr.ch/tbs/doc.nsf/ (Symbol)/84ab9690ccd81fc7c12563ed0046fae3?Opendocument (accessed 8 March 2007), par. 5.
\item \textsuperscript{26} See supra GC 12 CESCR, no. 50, par. 18.
\item \textsuperscript{27} See supra GC 16 CESCR, no. 34, par. 28.
\item \textsuperscript{28} See supra GR 24 CEDAW, no. 33, par. 7.
\item \textsuperscript{29} See supra Campaign to End Fistula, no. 2.
\item \textsuperscript{30} See supra F. Donnay, L. Weil, no. 9, p. 72.
\item \textsuperscript{31} See supra L. L. Wall, no. 4, p. 1207.
\item \textsuperscript{32} See supra F. Donnay, L. Weil, no. 9, p. 72.
\item \textsuperscript{33} Ibid, p. 1204.
\end{itemize}
Human rights approach as persons with disability

Obstetric fistula can be defined as a pregnancy-related disability on the basis of several Conventions and their interpretations.

In 1994 CESCR, in defining people with disabilities, pointed out that “people may be disabled by physical […], medical conditions or illness” and that “such impairment, conditions, or illness may be permanent or transitory in nature.”

Moreover the new Convention on the Rights of Persons with Disabilities includes in the definition the persons “who have long-term physical […] impairments which […] may hinder their full and effective participation in society on an equal basis with others”; this definition is on the same track of the one given by the specific convention elaborated within the Inter-American system. As obstetric fistula is a physical impairment lasting until when properly treated, it is possible to consider women affected by it as persons with a disability. Not to mention the fact that in cases where the fistula gives rise to foot drop, these women would be considered persons with disabilities also whether successfully treated for the fistula.

The Convention on the Rights of Persons with Disabilities defining discrimination on the basis of disability includes any “exclusion […] on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.” As women affected by fistula are incontinent, they are often abandoned by their families, cast out by the society, and isolated. This kind of marginalization can definitely enters in the definition of discrimination given above, as they are discriminated on the basis of the fact that they are incontinent, part and consequence of their disability. Therefore as the new Convention and the American Convention prohibit discrimination on the grounds of disability, and obstetric fistula can be considered a disability, states that ratified those instruments have the obligation to take positive steps to eliminate discrimination of women living with obstetric fistula, as subject to multiple discrimination, as women and as persons with disability.

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38 See infra Convention on the Rights of Persons with Disabilities, no. 128, art. 2.
40 See infra R.J. Cook, B.M. Dickens, M.F. Fathalla, Reproductive Health ..., no. 82, p.208.
41 See supra Convention on the Rights of Persons with Disabilities, no. 128, art. 6.
States are moreover requested to take steps to deal with the particular situation of women with disability, including special measures in order “to ensure that they have equal access to education and employment, health services and social security, and to ensure that they can participate in all areas of social and cultural life” 42.

In an extensive interpretation of art.26 of the Convention on the Rights of Persons with Disabilities, requesting states to “strengthen and extend comprehensive habilitation and rehabilitation services and programmes” 43, it could be read that the rehabilitation service for women affected by fistula would be its reparation. This reading is supported by the definition of rehabilitation given by the World Program of Action Concerning Disabled People that considers rehabilitation as “a goal-oriented and time-limited process aimed at enabling an impaired person to reach an optimum mental, physical and/or social functional level, thus providing her or him with the tools to change her or his own life” 44. From this reading it can be argued that the surgery reparation of obstetric fistula fits within the definition.

The concept of non discrimination on the basis of sex is specifically included in four of the six major human rights treaties which are currently in force 45, without considering the Convention on Disabilities, entered in force on May 2008. Moreover it is important to observe that international human rights instruments allowing derogations do not allow them in case of discrimination 46. With regard to the right to health, one of the core obligations outlined by CESCR is “to ensure the right of access to health facilities, goods and services on a non-discriminatory basis” 47. In general the principle of non discrimination is a justiciable right, not only under international law, but in most domestic legal systems as well 48. This great emphasis given to discrimination by international and national laws shows the particular interest of the international community in order to avoid it. Therefore, once again, it is important to stress that as obstetric fistula entails a discriminatory attitude, the international community should strive more in order to face the problem and to eradicate it, preventing and treating obstetric fistula.

Based on research essay conducted in 2007 by Paolo G. Marchi LLM in International Human Rights Law; University of Essex; Colchester, UK

43 Ibid, art. 26 (1).
46 See e.g. art. 4.1 ICCPR, art. 27 (1) American Convention on Human Rights.
47 See supra GC 14 CESCR, no. 34, par. 44 (a).
48 See supra A.E. Yamin, no. 77, p. 124.
CCM program in Ethiopia

The “Strengthening Essential Obstetric Care services and increasing their utilisation in Bale Zone, Oromia Region, Ethiopia “ project began in January 2005 and was concluded by April 2009.

The aim of the project was to reduce maternal and neonatal mortality in Bale Zone by strengthening and expanding maternal health services, by implementing an integrated and holistic approach to maternal health, by providing efficient delivery of care for emergency obstetric complications in addition to ongoing maternal health care services.

The target groups were represented largely by the communities living in the area of intervention, in particular pregnant women and neonates, and by the government health staff involved in maternal health services. The project was to implement actions both at service delivery and at community level so as to ensure that women and their newborns have access to skilled care. Being in partnership with local health authorities, the project envisioned to provide training of managerial and clinical staff, provision of essential equipment and supply, development of guidelines and protocols, actions aimed at empowering women, families and communities to improve and increase their control over maternal and newborn health, as well as increasing access and utilization of quality health services. The team also found out that at hospital level, a highly qualified and experienced gynecologist was seconded with the responsibility of initiating and strengthening the activities in the obstetric department of Goba hospital. The local general practitioners were trained in performing basic medical and surgical obstetric procedures. Midwives recruited from the target woreda health centres also upgraded their skills through the special training given to them with practical attachment at Goba hospital. Ward staff gained fairly enough competencies in providing nursing assistance to women before and after delivery and surgical interventions.

On top of its invaluable service for local beneficiaries, the establishment of effective EOC services at HCs benefited nursing college trainees in their practical activities.

The special and practical training due to the health extension workers at health post level acquired adequate competencies to provide antenatal and postnatal care, assisting normal deliveries, assess obstetric risks, identify complications and take necessary actions.

Traditional Birth Attendants who had received training by the project also ascertained that the practical training they received and their participation in the project implementation and review meetings enabled them to raise their awareness of antenatal and postnatal care.

Consistent to the project objective, a considerable number of people from different walks of life sensitized in maternal and neonatal health issues via workshops, community mobilization endeavors and mass awareness generation through IEC where documentary film, booklets, TV spots, radio broadcasting spots were developed and utilized.
A campaign to identify cases of obstetric fistula was conducted in Bale zone, in Ethiopia by the gynaecologist and 286 cases were reported.

The mean age of the women was 20 years. The mean duration of labour was 6 days and the mean duration of fistula was 4 years; 59% of them were primiparous. 283 have had vaginal delivery. 3 patients had a Caesarean section. Only one woman who developed a fistula after a Caesarean had a live baby. 3 of the 283 (1.1%) women who developed a fistula after vaginal delivery had a live baby.

There were some associated complication such as neurological complications-foot drop, contractures (2%), second amenorrhea (60%), urine dermatitis, psychosocial complications. In Bale zone treatment of women suffering from fistula still remains impeded by a lack of access to specialized centre. In one year Goba Hospital, the only one present in the area, successfully managed six cases of VVF, eight cases have been repaired on selective basis, twenty one were referred to Addis Ababa Fistula Hospital (AAFH) due to limitation of infrastructure and complexity of cases.

Complicated cases, besides requiring very complex surgical interventions, that require highly specialization, they also have a need for skilled nursing care, hardly available in Goba Hospital. Some nurses were sent to AAFH to specialize in this post-surgery support, but the structure doesn't ensure an adequate assistance yet.

CCM project in Bale, by strengthening Essential Obstetric Care services and implementing the IEC program with women will reduce the FVV prevalence, but it is important that all the area will have its health centres and accessible services.

Noemi Bertolotti
Comitato Collaborazione Medica