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She did the right thing: the high price of poor access to obstetric care

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Up to 100 000 women each year in low-resource settings develop a new obstetric fistula (www.endfistula.org/). Programmes have been scaled up to prevent fistulas, to repair them, and to assist in reintegrating women after repair. Unfortunately, obstetric fistulas still occur.

AM is a 24-year-old woman who developed a vesicovaginal fistula in 2009, when she was in labour for approximately 48 hours. She received antenatal care, but delivered a stillborn fetus at home with the assistance of a relative. She came to a fistula repair center in 2011, approximately 100 km from her home, after leaking urine constantly after the delivery, and was found to have a 2 × 2 cm circumferential vesicovaginal fistula with severe fibrosis. She underwent surgical repair and was found to be continent and stable for discharge on postoperative day 20. She received extensive postoperative instructions and was advised that she would need a caesarean delivery were she to become pregnant in the future. She returned for two follow-up visits and was found to have returned to her baseline social functioning, was still married and still continent. She conceived 2 years later, received antenatal care, and reported to the regional district hospital approximately 1 month before her due date, as she lived in an area that was remote from health care. At the first sign of

labour, she notified the staff at the hospital, who were aware of her history of a fistula and need for caesarean delivery. Care was delayed at the district facility because of shortages of supplies and staff. After 20 hours of labour, she was then referred to the central referral hospital for the caesarean delivery. She waited approximately 24 hours there before the caesarean was performed. The fetus was found to be stillborn and she required a hysterectomy to control the bleeding. She began leaking urine soon after the surgery, and reported to the fistula repair center again, with a second fistula, which was fortunately closed successfully.

AM did everything she was instructed to do for her second pregnancy. Pervasive shortages in supplies and staff resulted in delay after delay. The vast majority of sub-Saharan Africa remains with care that mirrors that received by AM.

High-quality healthcare facilities must be staffed by well-trained providers, who are able to perform safe and reliable caesarean deliveries in a timely fashion. Task shifting to other healthcare professionals works for routine caesarean deliveries, but the difficult caesarean delivery will probably always be under the purview of the obstetrician gynaecologist. Improving the struc-

ture and function of the yet unproven maternity waiting home for those women who live in remote areas or who are at high risk may be part of the solution until quality health care is available locally for all. AM remains a stark reminder of what happens every day to mothers in low-resource settings even when they do everything right.

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All authors contributed to the conceptualisation, writing and editing of this manuscript. JW created the idea.

Details of ethics approval

All women at the Fistula Care Center are consented for use of personal information and images to promote awareness and improve fistula care. This woman has also given consent for her case to be published.

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