Obstetric Fistula e-Learning Course (2024 update)

Course Participant Report – GFMER Obstetric Fistula e-Learning Course (2024 Update)

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A total of 247 health professionals from 48 countries attended the online training course on obstetric fistula between October 2024 to May 2025. Majority of the participants (43.3%) were in the age group 25 to 34 years (Table 1) and men made up 57.5% of participants (Table 2).

Table 1. Age of participants

Age range (years)	Number of participants	%
18-24	35	14.2%
25-34	107	43.3%
35-44	79	32%
45-54	20	8.1%
>55	6	2.4%
Total	**247**	**100%**

Table 2. Gender of participants

Gender	Number of participants	%
Men	142	57.5%
Women	105	42.5%
Total	**247**	**100%**

This course was attended by health professionals mainly from the African Region (62.8%) and Eastern Mediterranean Region (24.7%) (Table 3).

Table 3. Geographic distribution of participants by WHO Regions

WHO Regions	Number of participants	%
African Region (AFR)	155	62.8%
Eastern Mediterranean Region (EMR)	61	24.7%
Region of the Americas (AMR)	13	5.3%
South-East Asian Region (SEAR)	9	3.6%
European Region (EUR)	8	3.2%

Western Pacific Region (WPR)	1	0.4%
Total	**247**	**100%**

Participants worked in a variety of professions, most commonly as medical doctors (35.6%), midwives (17%), and nurses (13%) (Table 4). The majority were from government organizations (25.9%), government hospitals, clinics, and medical offices (22.3%), and the academic sector (10.9%) (Table 5). The country with the highest representation of participants was Ethiopia (17.8%) (Table 6).

Table 4. Participants' professions

Profession	Number of participants	%
Medical Doctor*	88	35.6%
Midwife	42	17%
Nurse	32	13%
Researcher	22	8.9%
Other**	17	6.9%
Student***	16	6.5%
Clinical Officer	15	6.1%
Academia****	13	5.2%
Pharmacist	2	0.8%
Total	**247**	**100%**

*Types of medical doctors represented include obstetricians and gynecologists, general surgeons, urologists, and general practitioners.
**Other includes health specialists in public health, community health workers, care workers, and nutrition.
***Types of students include those studying medicine, nursing, and midwifery
****Types of academia include professors and lecturers.

Table 5. Distribution of participants by type of organization

Organization type	Number of participants	%
Government organizations	64	25.9%
Government hospitals, clinics, and medical offices	55	22.3%
Academic sectors	27	10.9%
Private organizations	26	10.5%
Local NGOs	22	8.9%
International NGOs	18	7.3%
Non-government hospitals, clinics, and medical offices	18	7.3%
International organizations	8	3.2%
Others	7	2.8%
Civil societies	2	0.8%
Total	**247**	**100%**

Table 6. Distribution of participants by country

Country	Number of participants	%
Afghanistan	1	0.4%
Albania	1	0.4%
Argentina	1	0.4%
Australia	1	0.4%
Bahrain	3	1.2%
Bangladesh	1	0.4%
Brazil	1	0.4%
Burkina Faso	4	1.6%
Cameroon	3	1.2%
Canada	1	0.4%
Chad	5	2%
DR Congo	1	0.4%
Egypt	2	0.8%
Eritrea	1	0.4%
Ethiopia	44	17.8%
Finland	1	0.4%
Gambia	1	0.4%
Ghana	5	2%
Greece	1	0.4%
India	6	2.4%
Indonesia	1	0.4%
Iran	12	4.9%
Iraq	1	0.4%
Ireland	1	0.4%
Italy	2	0.8%
Kenya	20	8.1%
Liberia	1	0.4%
Malawi	2	0.8%
Mexico	5	2%
Myanmar	1	0.4%
Namibia	2	0.8%
Nigeria	23	9.3%
Pakistan	7	3.1%
Qatar	1	0.4%
Republica Dominicana	1	0.4%
Saudi Arabia	1	0.4%
Sierra Leone	4	1.6%
Somalia	30	12.1%
Somaliland	2	0.8%

South Sudan	6	2.4%
Sudan	1	0.4%
Tanzania	7	3.1%
Togo	1	0.4%
Uganda	14	5.7%
United Kingdom	2	0.8%
United States	4	1.6%
Zambia	9	3.6%
Zimbabwe	2	0.8%
Total	**247**	**100%**

Current Situation/Additional Information on Obstetric Fistula (OF) – Country Context

Course feedback provided an opportunity for health professionals to discuss current in-country situations or additional information regarding obstetric fistula. The countries listed contain relevant and summarized feedback from participants.

Albania: Not many noted cases of obstetric fistula.

Argentina: Not a common observed health outcome.

Bahrain: Underreported and a low prevalence is reported. However obstetric fistula remains a significant public health issue, particularly in rural areas.

Bangladesh: Fairly prevalent public health issue.

Cameroon: Three primary causes of OF in Cameroon include obstructed labor, perineal tears, and trauma (to the body, especially sexual violence).

Chad: OF remains a public health issue. There are currently no guidelines for fistula management. Challenges in treating fistula include lack of medical equipment and lack of medical specialists.

DR Congo: Three primary causes of OF include prolonged labor, late Caesarean section, and forced marriage.

Eritrea: In Eritrea, the Eritrean Obstetric Fistula Project was launched in 2002. Four core agendas include training of clinicians for obstetric fistula (prevention, repair, and overall management), provision of drugs and supplies necessary for fistula care, establishment of a dedicated fistula center, and community awareness for positive maternal health behaviors.

Ethiopia: OF remains a significant public health issue in Ethiopia with three primary causes being obstructed labor, lack of timely medical intervention, and early marriages. Multiple treatment and prevention services exist in Ethiopia however access to these services remains an issue due to medical deserts, limited availability of surgeons, and delayed reporting of OF cases.

Gambia: Three primary causes of OF include obstructed labor, child marriage, and infibulation due to FGM. There is a fistula management center at a private hospital in Gambia that provides free medical services for those with obstetric fistula.

Ghana: OF remains a significant public health issue in Ghana with three primary causes being poverty, early marriages, and lack of education. Ghana has multiple prevention and treatment services available that include social reintegration programs.

Greece: Follows relevant national guidelines developed by the Ministry of Health.

India: OF remains a significant public health issue in India with three primary causes being obstructed labor, lack of skilled birth attendant, and early marriage. Multiple fistula treatment centers can be found in India which provide free surgical interventions.

Indonesia: Three primary causes of OF include prolonged obstructed labor, iatrogenic injures, and vaginal stenosis. Specifically in Jakarta, there are several services for the prevention and treatment of OF such as specialized medical facilities, rehabilitation programs, and social reintegration support.

Iran: Three primary causes of OF in Iran include prolonged labor, interventions during childbirth, and obstetric trauma. Limited country-specific information exists.

Kenya: OF remains a significant public health issue in Kenya with three primary causes being obstructed labor, adolescent pregnancies, and lack of access to timely care. Facilities offer both surgical intervention and social reintegration programs.

Liberia: Three primary causes of OF include prolonged and obstructed labor, early marriage, and limited access to maternal healthcare services (particularly in rural areas). Liberia follows the WHO guidelines for the clinical management of obstetric fistula, additionally there are national guidelines.

Malawi: Significant underreporting of OF cases can be observed in Malawi. Three primary causes of OF include early marriages, poor access to health facilities, and low literacy levels. Facilities such as the Nkhoma Mission Hospital treat obstetric fistula for free. However, social reintegration programs are not as commonly found.

Mexico: Three primary causes of OF in Mexico include obstetric trauma, surgical complications, and radiation therapy.

Myanmar: No national guidelines.

Namibia: OF remains a significant public health issue in Namibia with three primary causes including limited access to quality maternal healthcare, high rates of adolescent pregnancies, and cultural practices that discourage seeking medical care during childbirth.

Nigeria: OF remains a significant public health issue in Nigeria with three primary causes including prolonged and obstructed labor, early marriage, and limited access to quality maternal healthcare. Prevention and treatment services are expanding across Nigeria. While social reintegration programs are not as frequently implemented, the use and awareness of these programs are also expanding.

Pakistan: OF remains a significant public health issue in Pakistan with three primary causes including prolonged labor without access to medical care, poor access to quality

healthcare, and child marriage. Improvements have been made to prevention and treatment services such as access to emergency obstetric care, family planning education and services, repair surgeries, and social reintegration programs.

Saudi Arabia: Currently no country-wide guidelines or specialized centers.

Sierra Leone: Three primary causes of OF include prolonged and obstructed labor, limited access to quality maternal healthcare services, and early marriage. The government has established obstetric fistula operating facilities.

Somalia: OF remains a significant public health issue in Somalia, particularly in rural areas where access to emergency obstetric care is limited. Primary causes include inadequate healthcare infrastructure, a lack of skilled healthcare providers, and cultural practices that delay access to timely medical intervention. The healthcare system in Somalia is still recovering from years of conflict and instability, which has severely impacted maternal healthcare services. However, certain hospitals in urban areas have started to offer surgical repair for fistula patients. Additionally, psychological support and social reintegration programs are becoming more common.

Somaliland: OF remains a significant public health issue in Somaliland. Three primary reasons include limited access to quality maternal healthcare, high rates of home births without skilled attendants, and socio-cultural factors such as early marriages. Data on prevalence is limited but contributing factors suggest a notable occurrence of obstetric fistula in the region.

South Sudan: Primary causes of OF include high number of adolescent pregnancies, shortage of skilled birth attendants, and poor road infrastructure. South Sudan has a fragile health system which also plays a role.

Sudan: OF remains a significant public health issue, specifically considering the Sudanese civil war. Three primary causes include remote and isolated areas that are far from health facilities, lack of transportation to medical facilities, and lack of trained professionals. The treatment level for OF is currently very poor. Additionally, many families have resorted to marrying their daughters due to the conflict and this has resulted in additional child marriages.

Tanzania: OF remains a significant public health issue, particularly in rural areas with few skilled birth attendants. Many women are living with untreated fistulas. Three primary causes are obstructed and prolonged labor, early marriages leading to adolescent pregnancies, and limited access to healthcare. Progress has been made in Tanzania regarding treating OF in terms of surgical repair, prevention programs, and social reintegration.

Togo: Primary causes of OF include obstructed labor, traditional cultural practices, and lack of access to obstetric care.

Uganda: OF remains a significant public health issue. Three primary causes include prolonged and obstructed labor (due to limited access to emergency obstetric care), teen pregnancy and early marriages, as well as iatrogenic injuries. In-country resources address fistulas through surgical repair, counseling, and social reintegration programs.

United Kingdom: Low prevalence with most fistulas being iatrogenic following surgery or radiotherapy or being associated with cancer.

Zambia: Main causes of fistula in Zambia include iatrogenic, being cancer-related, and sexual violence. Programs in-country such as community health education, laws on sexual violence, and provisions of new health care settings in communities have been implemented.

Zimbabwe: OF remains a significant public health issue. Three primary causes of OF in Zimbabwe include obstructed labor, often related to early marriages and inadequate access to skilled birth attendants; prolonged labor without timely medical intervention; and complications arising from unsafe abortions. There are several in-country programs (ex. emergency obstetric care at local health facilities and the involvement of NGOs that offer surgical repair services).

To conclude, the burden and etiology of obstetric fistula differ between low- and middle-income countries (LMICs) in comparison to high-income countries (HICs). In LMICs, obstetric fistula is commonly associated with prolonged or obstructed labor, early marriage, adolescent pregnancy, and delayed access to emergency obstetric care. Meanwhile for HICs, obstetric fistula is rare, with most cases resulting from iatrogenic causes.

These disparities emphasize the need for national-level prevention and treatment strategies. Key priorities include improving access to emergency obstetric care and quality maternal healthcare, expanding rehabilitation services, and implementing community-level interventions that address social determinants of health. These efforts have the potential to support capacity building and contribute to reducing the global burden of obstetric fistula.

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