REPUBLICA DE GUINEA ECUATORIAL
MINISTERIO DE SANIDAD
Y BIENESTAR SOCIAL

FONDO DE POBLACION
DE LAS NACIONES UNIDAS

COMUNIDAD
ECONOMICA EUROPEA

NATIONAL PROGRAMME FOR REPRODUCTIVE HEALTH

NATIONAL SURVEY ON OBSTETRIC FISTULA IN EQUATORIAL GUINEA

FINAL REPORT

PREPARED BY:

THE NATIONAL RESEARCH TEAM

Under the technical assistance
of the International Expert for Reproductive Health:
Mr. Oumar Balde

Bata, July 2005

FOREWORD

The objective of the Equatorial GuineaN National Policy on health is to improve the status of the population through the available ressources (infrastructures, materials, equipment, personnel, etc). This national policy is based on the promotion of the accesibility to an integrated health assistance, well qualified services to the population as well as to permit a full participation of the community in the management and finance of health activities.

Regarding the Reproductive Health matters, this policy is being applied through a National Policy and Programme for Reproductive Health (RH) through the 1994 Cairo Conference (ICPD) recommendations, the African Strategy on RH, the Milenium Development Goals (MDG), the National RH Simposium held in Mongomo (2002), the 2004 Dakar CIPD + 10 recommendations, etc., in order to increase the availability and utilization of the RH qualified services for all the target group during all the world stages, up to 2015. However, the lack of assistance during childbirth operations by qualified personnel and the lack of health evacuation due to obstetric emmergencies, leads to complicated deliveries that produces temporary or definitive sequences to parturients which starts from simple scratches to obstetric fistulas, difficult to quantify due to lack of statistical data.

The present report of the National Survey for Obstetric Fistula in Equatorial Guinea is a national reply to find the necessary statistical data on the measurement of this problem, with the assistance of the UNFPA and EU to find strategies to help the elimination of obstetric fistula in this country in support of the World Campaign lanced by the UNFPA up to 2010.

With the result found at national level through systematic visits to the population, village councils, neighborhood communities at district level I am convinced that the population has collaborated greatly in the obtention of this data and that the search of further cases on obstetric fistula will be a continuing activity.

With the hope that this report, with its recommendations helps the Government, its partners on RH to improve the maternal health, I wish to thank the President of Equatorial Guinea, H.E. Obiang Nguema Mbasogo, for to his constant support to the Health Sector, the Reproductive Health for the execution of its plans for the well being of the population.

To all local authorities and all the community due to its close participation during all the process of this survey; to the UNFPA, the European Union, for the technical and financial assistance during the process held to finalize the survey; to the local team of national and international experts, for their efforts and contribution during the process of this scientific activity.

I hope that in the near future, the application of the work plan and the obstetrical fistula protocol of treatment will be a reality, as well as the recommendations of this report.

Bata, July 2005
DOCTOR JUSTINO OBAMA NVE,

MINISTRY OF HEALTH AND SOCIAL WELFARE

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ABREVIATIONS

ABIFAGE	Equatorial Guinea Family Well Being Association
CA	Community Agent
CANIGE	Support Committee for Equatorial Guinean Children
CAP	Knowledge, Attituds and Practices
CIPD	International Conference for Population and Development
ESOC	Essential Obstetric Care
EMOC	Emmergency Obstetric Care
VC	Village Council
PNT	Prenatal Consultation
NC	Neighborhood Council
SDCB	Service Distribution on Community Basis
HDS	Health and Demographic Survey
EPI	Education on Population Issues
EFL	Education for Family Life
UNFPA	United Nations Fund for Population Activities
IEC	Information, Education and Communication
IFORD	Training and Demographic Research Institut
STD	Sexually Transmmitted Deseases
J-20	Youth 20th Century
MHSW	Ministry of Health and Socia Wellbeing
WHO	Worl Health Organisation
NGO	Non Governamental Organisations
FP	Family Planning
NPHD	National Plan for Health Development
UNDP	United Nations Development Programme
AIDS	Acquired Immuno Defficiency Syndrome
HIS	Health Information System
RH	Reproductive Health
EU	European Union
UNICEF	United Nations Fund for Children
US $	United States Dollars
HIV	Human Immunodefficiency Virus

I. INTRODUCTIÓN AND JUSTIFICATIÓN

Equatorial Guinea with its satisfied national coverage in comparison to its modest size, has 18 public hospitals, 42 health centers as well as 291 health post. More than a half of the 291 health post are closed. Nearly 60% of the population reaches health centers within one hour walking (around a 5 km ratio). However, this indicator is difficult to increase the real level of effective utilization of health services, reduces the effective health services coverage due to the worst situation of the roads, the lack of transportation means, the low income of several families, the lack of equipment, drugs as well as defficient qualified personnel, etc.

Data provided by the few survey missions carried out in Equatorial Guinea shows that 1/3 of pregnant women interviewed in 1998 bennefited from one antenatal consultation during the last pregnancy, which means that most of these women did not benefit from the stablished RH follow up rules. Regarding the deliveries assisted by qualified personnel, its frequency decrease while provincial and regional maternity services are far from their place of residence. This situation is justified due to the increased level of pregnant women with most complicated delivery situations that risks their lifes during delivery and partum operations. Also criminal abortions made by non qualified personnel are frequents, specially by adults aged from 13 to 14 years old.

On the other hand, the correct deal on obstetric emmergencies is still critical due to the lack of acomplishment of the established technical rules in most hospitals, the insufficiency of national qualified personnel, the unavailability of essential drugs as well as medical fungible materials, etc. The quality of obstetric cares is also facing the organisation of transport to obstetric emmergencies due to the lack of vehicles, the insufficiency of economical ressources as well as the illiteracy of most families that contributes to delayed transfert of parturients to reference health centers.

Every year in the world, and in most cases in developing countries, some 50.000 to 100.000 women are affected by obstetric fistula due to the lack of accessibility to the necessary obstetric cares.

The scarced delivery assistance by trained personnel and the delayed or lack of health evacuations to obstetric urgencies, leads to complicated deliveries which produces temporary or definitive traces such as simple perineal scratches to obstetric fistulas, difficult to evaluate due to the lack of available statistical data in Equatorial Guinea.

Obstetric fistula is caused by a difficult and prolonged delivery, linked to the lack of an appropriate obstetric operation, such as caesarian. Constant pression to foetus's head over mother's basin, causes a tissue tear, fistula, between the vagina and the bladder and/or rectus. This causes a chronic incontinency with social life destructive effects for the woman. Besides woman's humiliation resulting from the uncontroled flow of urin and feaces.

Fistuled woman become rejected by her housband and considered responsible of the sickness; almost the totality of the cases, babies always dies. Some women beneffites from their familis'help, but with serious difficulties to be accepted by the community.

Skin hygien problems due to the lack of appropriate products, antiseptic solutions and medical and social conseiling/assistance makes that fistuled women be excluded in family and extrafamily activities without any sexual relations with housbands and/or couple.

This social discrimination or stigmatisation increases fistuled women's isolation as desapearance; decreases their physical capacities, makes worse their poverty situation and finally lead them to decease.

The absence of quantified figures in Equatorial Guinea, the most affected women are those placed in the most scarced geographic accessibility and found in unaccessible locations in the continental and island regions. These localities are generaly in lack of qualified personnel, drugs and minimal medical equipment, as well as appropriate infrastructures to offer quality services to the population.

This situation is linked to the defficiency of vehicles to ensure the transportation of obstetric emmergencies to referral health centers.

In order to face this situation to dispose of the necessary available data on obstetric fistula, the Ministry of Health and Social Welfare, with the UNFPA and the European Union assistance has brought the attention of the Government to carry out a national survey to determine the level of incidence of fistula at national level through systematic visit to all village councils neihgborhood communities at district level around the country in order to take the appropriate measures with the implantation of a reparation and social reinsertion of fistuled women in Equatorial Guinea.

II . NATIONAL CONTEXT

Situated in the south area of the Gulf of Guinea, at the west site of central african area, Equatorial Guinea has a surface of 28.051,46 Square meters consisting of two clearly natural regions (the continental and insular regions). The island region includes the main island of the national territory called Bioko where is located the capital city, Malabo.

Data from the 2001 General Census for Population and Habitat estimated 1.014.999 habitants the total population of Equatorial Guinea distributed into two natural regions: 265.470 in the island region and 749.529 in the continental region. Women represents 52,51% of the population. The increase rate between the two census (1994 and 2001) represent 7,6%. The birth rate represents 43.2 times 1000 while the fertility rate represents 5.6 children times a woman at fertility age. The 0 – 14 years population represents a 47,30%. The mortality brute rate is around 13,7 times 1000, the mortality infants rate amounted to 93 times 1000, the infanto-juvenyl mortality rate is 50 times 1000, the maternal mortality rate is 352 times 100.000 birth alive while the life expectancy is 59,3 years.

Concerning the administrative organisation, Equatorial Guinea is divided into seven provinces, three of them are in the island region. The other four, in the continental region; both regions total 18 districts and 741 village councils found in the base territorial administration of the country and where are concentrated the beneficiaires of the population.

Economicaly, the oil production since 1995, makes that the economy of the country be florecient, inspite of the exceptional evolution of its growth economical indexes the development of Equatorial Guinea is facing a poverty situation of most of the population.

III. MAIN OBJECTIVES OF THE SURVEY

3.1. General objectif.

The general objective of the survey was to empower the availability of the credible data on obstetric fistula in Equatorial Guinea.

3.2. Specific objectives.

- To carry out data collection on existing health infrastructures as well as its handling capacities on obstetric fistula;

- To evaluate all existing social and community needs regarding the prevention, reparation and social reinsertion post operation of obstetric fistula;

- To evaluate all advocacy needs plans toward the political leaders health personnel and professional associations for the prevention, reparation and social reinsertion after operations;

- To carry out interviews with health personnel regarding the level of knowledge on obstetric fistula;

- To carry out interviews with women living with fistula on their socio economical status as well as their knowledge level on obstetric fistula.

IV. METHODOLOGY

The survey has been carried out completely and at national level around the 18 districts of the country. To ensure the participation of all the village councils and neighborhood communities as well as the full sensitisation of all the population on fistula, a four people team had been constituted at district level composed of the Hospital Director, three health agents including IEC most of them trained on IEC strategies in support of Reproductive Health in 2004 to cover the unsatisfied needs on sensitisation of the community.

The survey team previously benefited with a 5 days training in Bata and Luba on data collection policies as well as the ruling procedures for data collection at district level following the available collection tools and the indications received during the training. The supervision team constituted by two doctors from the Bata maternity service, a representative from the epidemiology section, the UNFPA international expert for RH. Totally, 96 pollster and supervisors were trained to cover all 741 village councils and neighborhoods communities around the 18 districts of the country.

They were distributed 3 to 4 pollsters at district level depending on the number of village councils and neighborhood communities to cover, 1 supervisor, the Director of the district hospital or his representative. The duration of the data collection was 10 days, giving priority to the most difficult access sites such as Annobón, Corisco, Ureca and certain areas of Mbini, Niefang, Nsocknsomo, Bata and Baney.

In each site surveyed, the pollster showed their credentials signed by local authorities to facilitate contacts and collaboration with Heads of all village councils and neighborhood communities, seek their certifications for the effective realisation within their areas, as it was stated during the training sesions and orientation to pollsters and supervisors. In each different site (VC and NC, health center, hospital, etc.) the differents stages followed by pollsters were the following:

- Contacts with local authorities of all communities, one day before the survey in order to inform them on the matter as a government priority, with assistance of the UNFPA and the European Union;

- Meeting with the local population, called upon by the President, the following day, at a convinient place chosen by local authorities to explain the context of the survey as well as to select the specific place to deal with the patients with obstetric fistula in addition to other women desseases and health problems, to facilitate the identification of obstetric fistula cases. In the case of low participation of community members, the pollsters visited all houses explaining family members and others ,the problem of obstetric fistula to avoid losing all opportunities of detection of obstetric fistula cases in the site;

- Interviews at district level with hospital directors, health personnel (doctors, gynecologists, midwives, nurses, etc.) as well as traditional midwives at community level;

- Interviews with all women identified with obstetric fistula, using the necessary tools prepared for the survey;

- Gratefulness to the community and all council members and neighborhood communities, by the pollsters and supervisors ensuring that women with obstetrict fistula and their families will have the opportunity to benefit from assistance and free reparations by the Government, UNFPA and the European Union.

In fact, the survey was conducted globaly through interviews with the convened tools during the training sessions of pollsters which was addressed to health personnel to evaluate the capacities of the infrastructures for reparation of obstetric fistula; to evaluate the knowledge level of all health agents on obstetric fistula as well as the situation of women themselves living with obstetric fistula at family and social environment.

V. DATA ANÁLYSIS AND VALIDATIÓN

The data processing session was conducted by a team of national professional personnel, technically assisted by the UNFPA International Expert on Reproductive Health as well as the participation of an experienced doctor of the cuban cooperation team in Equatorial Guinea, Professor Perrera. This exercise had a duration of 10 days, including the preparation of this final report.

During the period of data analysis, the editing team analyzed and validated the purpose of reparation of obstetric fistula.

The presentation and validation of the report will be conducted through a national meeting, headed by the Minister of Health and Social Welfare, with the participation of all social sectors and Reproductive Health partners in the country.

VI. DIFFICULTIES

6.1. The initiation of the survey at field level was not made on time due to delayed information given to local authorities (Government Delegates) who should facilitate the transportation of the survey teams.

6.2. Some village council heads and neighborhoods community members have no official stamps to certify the government credencials for the use of pollsters in their areas.

6.3. The rainy season also coincided with the survey period, that made difficult the data collection in certain areas, so that the programme stablished such as the sentisization of the population, interviews and site visits was delayed.

6.4. The utilisation of communication equipment during the survey process which was not budgeted, created additional expenses to supervisors also did not allow a wide difussion of the messages on the development of the survey in certain sites.

6.5. The execution period of the survey at field level was not sufficient due to the fact that the survey was conducted during the rainy period in the island region of Bioko.

VII. DATA ANALYSIS

At national level, the survey was conducted in all the zones of the country (urban and rural areas) at village council and neighborhood community level with a full participation of all local authorities of these basic country statements. 71 fistula cases were found, of which, 66 obstetric and 5 traumatics, which most of them under 35 years old.

7.1. Prevention and handling process of obstetric fistulas.

(i) Capacities of health infrastructures for the handling of obstetric fistula.

With regard to health structures covered by the survey on obstetric fistula, 16 hospital directors over the 18 available, (89%) were interviewed on the capacities of these structures to ensure the reparation of the obstetric fistula. However, the director of the regional hospital of Malabo was not visited due to its limited agenda. This did not permit to dispose of all the necessary informations on the possibilities of such hospital to accommodate women with obstetric fistula.

At national level, regional hospitals in Malabo and Bata, including Loeri Comba clinic, are the institutional hospitals that can find all the conditions to carried out reparation processes of obsttric fistula. This opportunity is justified due to the disponibility of an adequate equipment in surgical services as well as a quallified team of personnel, specially the cuban cooperation team. However, this strategy is not sustained to the fact that local personnel is not yet trained to ensure the responsibility of reparation of obstetric fistula.

At intermediate level, where the provincial hospitals can warranty the reference cares for district hospitals with a reduced number of personnel should be reinforced to offer an adequate and qualified handling of obstetric fistula decreasing the appearance of obstetric fistula through early cesarian operations.

Also the periferic level where district hospitals and health centers integrates reproductive health services should also be reinforced to assume overall basic cares and that constitute an interface between the reproductive health services and the community beneficiary of such services.

At short term the Ministry of Health and Social Welfare will take all the necessary measures to operationalize 2 units of reparation of obstetric fistula in the regional hospitals of Malabo and Bata in collaboration with the participation of the following services: urology, surgeon and ginecology of these health structures, and which will benefit from the assistance of the cuban cooperation team. Special priority should also be given to the training of 4 national personnel abroad on reparation of obstetric fistula with support from UNFPA at specialized center level to that effect.

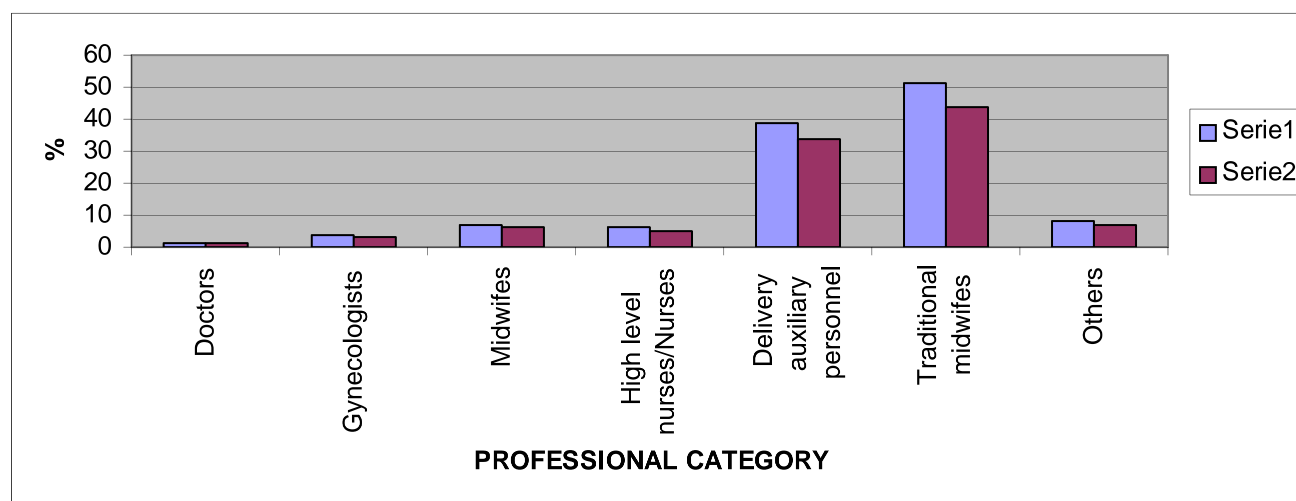
(ii) Capacities of health personnel on prevention and handling of obstetric fistula.

TABLE 1:

CATEGORIES OF DELIVERY ATTENDANCE PERSONNEL INTERVIEWED (JUNE 2005)

CATEGORY OF PERSONNEL	TOTAL	%
Doctors	1	1
Gynecologists	4	3
Midwifes	7	6
High level nurses/Nurses	6	5
Delivery auxiliary personnel	39	34
Traditional midwifes	51	44
Others	8	7
TOTAL	***116***	***100***

GRAPHIC 1:
PROPORTION OF DELIVERY ATTENDANCE PERSONNEL EQUATORIAL GUINEA (JUNE 2005)



Comments:

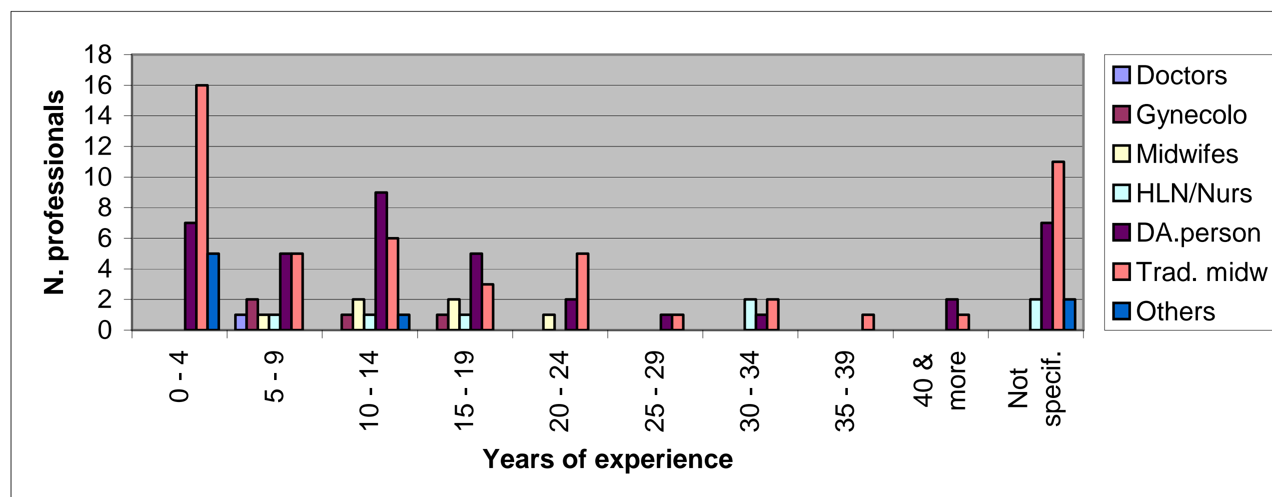
The table of delivery attendance personnel interviewed in June 2005, gives an indication of the insufficient number of qualified personnel where generalist doctors represents 1%, followed by gynecologists (3%) and while the nurses and trained midwives (11%). This shows the evidence of the aparition of obstetric fistula in Equatorial Guinea as the delivery attendance personnel (34%) and the traditional midwives (44%) represents the majority of the personnel attending deliveries in Equatorial Guinea. With the availability of the 72 doctors to be graduated in the Bata University (UNGE), the Faculty of Medicin in Bata, as well as the other groups about to be graduated in Cuba universities, the training programme of 120 midwives in Bata University up to 2010 by the National Programme for Repropdutive Health, a positive change of this situation is envisaged in the near future.

TABLE 2:

DISTRIBUTION OF DELIVERY ASSISTANCE PERSONNEL, BY YEARS OF PROFESSIONAL EXPERIENCE (JUNE 2005)

PROFESS EXPERIEN (YEARS)	HEALTH PERSONNEL							
	Doctors	Gynecolo	Midwifes	HLN/Nurs	DA.person	Trad. midw	Others	**TOTAL**
0 - 4	0	0	0	0	7	16	5	***28***
5 - 9	1	2	1	1	5	5	0	***15***
10 - 14	0	1	2	1	9	6	1	***20***
15 - 19	0	1	2	1	5	3	0	***12***
20 - 24	0	0	1	0	2	5	0	***8***
25 - 29	0	0	0	0	1	1	0	***2***
30 - 34	0	0	0	2	1	2	0	***5***
35 - 39	0	0	0	0	0	1	0	***1***
40 & more	0	0	0	0	2	1	0	***3***
Not specif.	0	0	0	2	7	11	2	***22***
TOTAL	***1***	***4***	***6***	***7***	***39***	***51***	***8***	***116***

GRAPHIC 2:
DISTRIBUTION OF DELIVERY ASSISTANCE PERSONNEL BY YEARS AND CATEGORY OF PROFESSIONAL EXPERIENCE JUNE 2005



Comments :

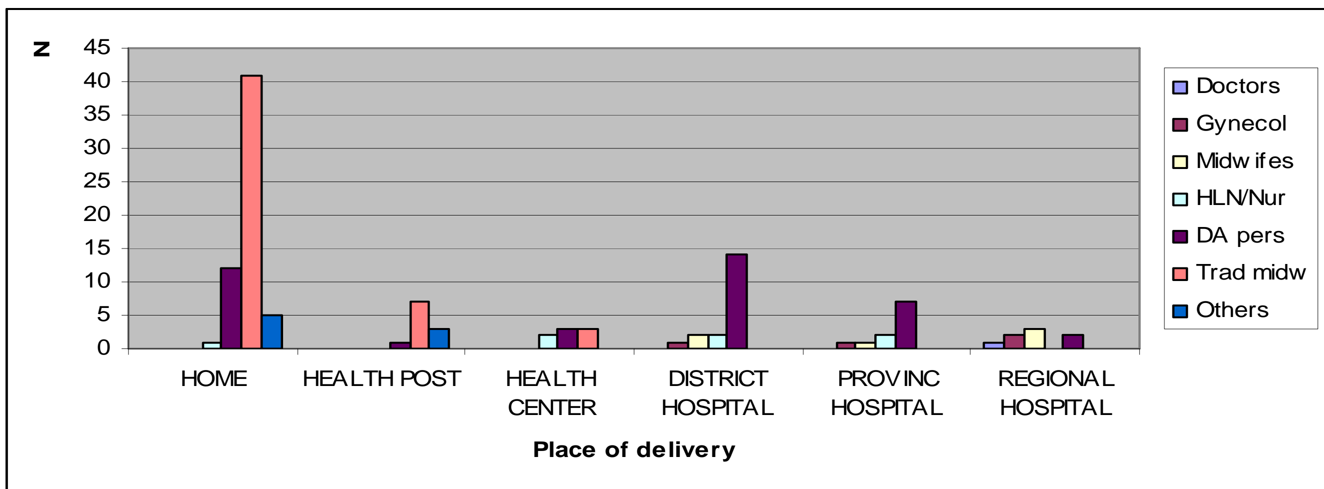
The analysis of the distribution of delivery assistance personnel by years and category of professional experience shows that most of the deliveries have been conducted by less than 20 years of professional experience personnel. This personnel, most of them are traditional midwives and delivery auxilliar personnel which represents 78% of the effectif interviewed and not trained to conduct deliveries. Consequently these most influenced women among the population (trad. midw) should be trained, motivated and receive close supervision in order to improve delivery assistance process as well as to reduce obstetric fistula in Equatorial Guinea.

TABLE 3:

DELIVERY ASSISTANCE PERSONNEL, BY SITE OF DELIVERY (JUNE 2005)

SITE OF DELIVERY	HEALTH PERSONNEL							TOTAL
	Doctors	Gynecol	Midwifes	HLN/Nur	DA pers	Trad midw	Otros	
HOME	0	0	0	1	12	41	5	*59*
HEALTH POST	0	0	0	0	1	7	3	*11*
HEALTH CENTER	0	0	0	2	3	3	0	*8*
DISTRICT HOSPITAL	0	1	2	2	14	0	0	*19*
PROVINC HOSPITAL	0	1	1	2	7	0	0	*11*
REGIONAL HOSPITAL	1	2	3	0	2	0	0	*8*
TOTAL	***1***	***4***	***6***	***7***	***39***	***51***	***8***	***116***

GRAPHIC 3:
DISTRIBUTION OF DELIVERY ASSISTANCE PERSONNEL BY SITE OF DELIVERY JUNE 2005



Comments:

During the survey 116 health personnel and traditional midwives who attended deliveries were interviewed. It was observed that most of the deliveries of the parturients were conducted in their homes (51%), in health post and centers (16%) by health agents and traditional midwives. This is due to the less or lack of operativity of health structures and that most of the population lives in rural areas, situation that can explain the low utilization rates of health structures to conduct deliveries.

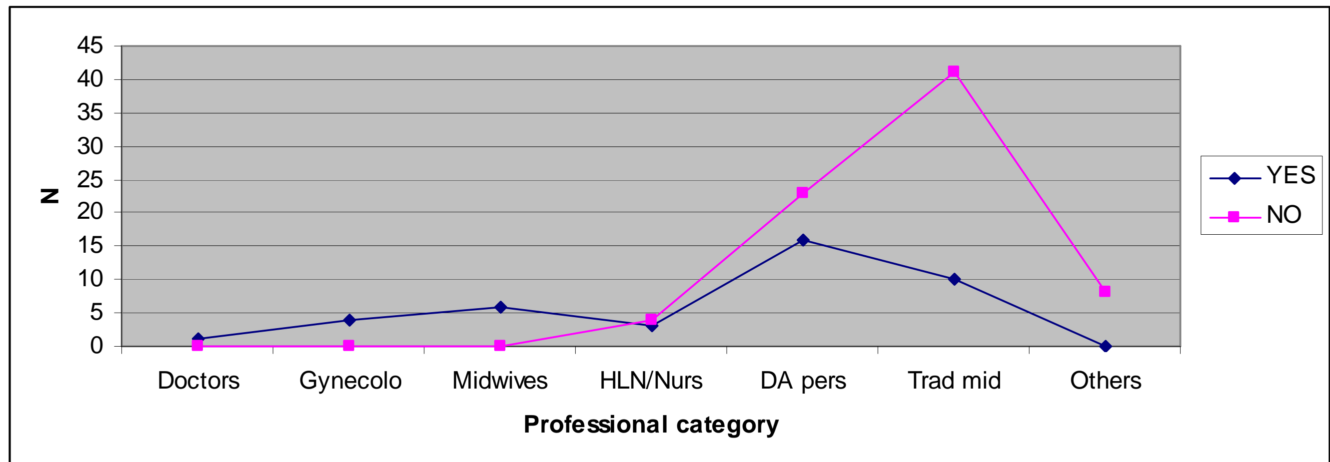
In addition, the bad conditions of the roads, the lack of transportation facilities and the low income of women and their families, as well as the lack of equipment, essential drugs and qualified personnel are also crucial. At short term and medium term the primary health cares should be reinforced with a most significant implication of the community through a training programme and utilization of traditional midwives and community personnel. The training of midwives should also be one of the priorities of the Reproductive Health Programme to promote maternal health care.

TABLE 4:

KNOWLEDGE LEVEL OF DELIVERY ASSISTANCE PERSONNEL ON THE DEFINITION OF OBSTETRIC FISTULA, BY PROFESSIONAL CATGEGORY (JUNE 2005)

KNOWLEDGE LEVEL	HEALTH PERSONNEL							
	Doctors	Gynecolo	Midwives	HLN/Nurs	DA pers	Trad mid	Others	*TOTAL*
YES	1	4	6	3	16	10	0	*40*
NO	0	0	0	4	23	41	8	*76*
TOTAL	*1*	*4*	*6*	*7*	*39*	*51*	*8*	*116*

GRAPHIC 4:
KNOWLEDGE LEVEL OF DELIVERY ASSISTANCE PERSONNEL ON THE DEFINITION OF OBSTETRIC FISTULA, BY PROFESSIONAL CATEGORY JUNE 2005



Comments:

Most of the interviewed delivery assistance personnel have no knowledge on the definition of obstetric fistula (76 cases); this represnts 66% with most incident on delivery auxiliar personnel and traditional midwives (64 cases), with 55% of the reply recorded.

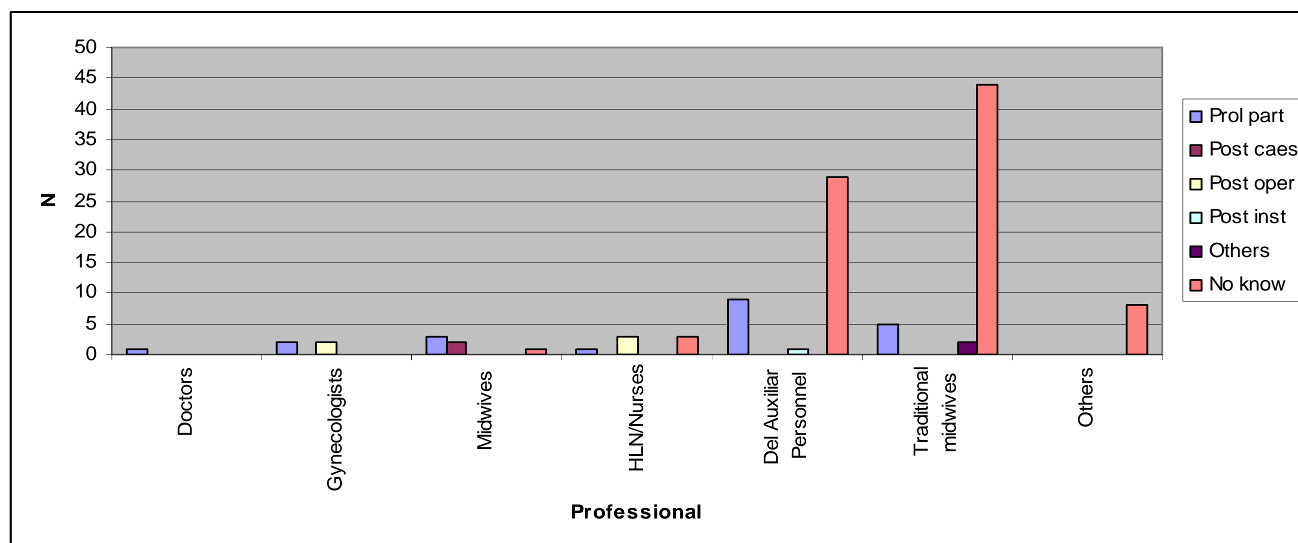
On the other hand, doctors, gynecologists, midwives and some of the high level nurses/nurses, which represents the 12% (14 cases), have well knowledge on obstetric fistula. This situation shows clearly the high number of obstetric fistula even the deliveries are institutionals. To solve this situation, the competence of the personnel on emmergency obstetric cares (EMOC) to prevent the appearance of fistula should be reinforced.

TABLE 5:

KNOWLEDGE LEVEL OF DELIVERY ASSISTANCE PERSONNEL ON THE CAUSES OF OBSTETRIC FISTULA (JUNE 2005)

HEALTH PERSONNEL	KNOWLEDGE OF THE CAUSES						TOTAL
	Prol part	Post caes	Post oper	Post inst	Others	No know	
Doctors	1	0	0	0	0	0	*1*
Gynecologists	2	0	2	0	0	0	*4*
Midwives	3	2	0	0	0	1	*6*
HLN/Nurses	1	0	3	0	0	3	*7*
Del Auxiliar Personnel	9	0	0	1	0	29	*39*
Traditional midwives	5	0	0	0	2	44	*51*
Others	0	0	0	0	0	8	*8*
TOTAL	***21***	***2***	***5***	***1***	***2***	***85***	***116***

GRAPHIC 5:
KNOWLEDGE LEVEL OF DELIVERY ASSISTANCE PERSONNEL ON THE CAUSES OF OBSTETRIC FISTULA (JUNE 2005)



Comments:

73% of the delivery assistance personnel interviewed (85 health agents) have no knowledge on the causes of obstetric fistula with most incidence on delivery auxiliar personnel and traditional midwives which 73 effectfs, represents 63% of the total of the interviewed personnel and they are the category which conducted deliveries during 2005.

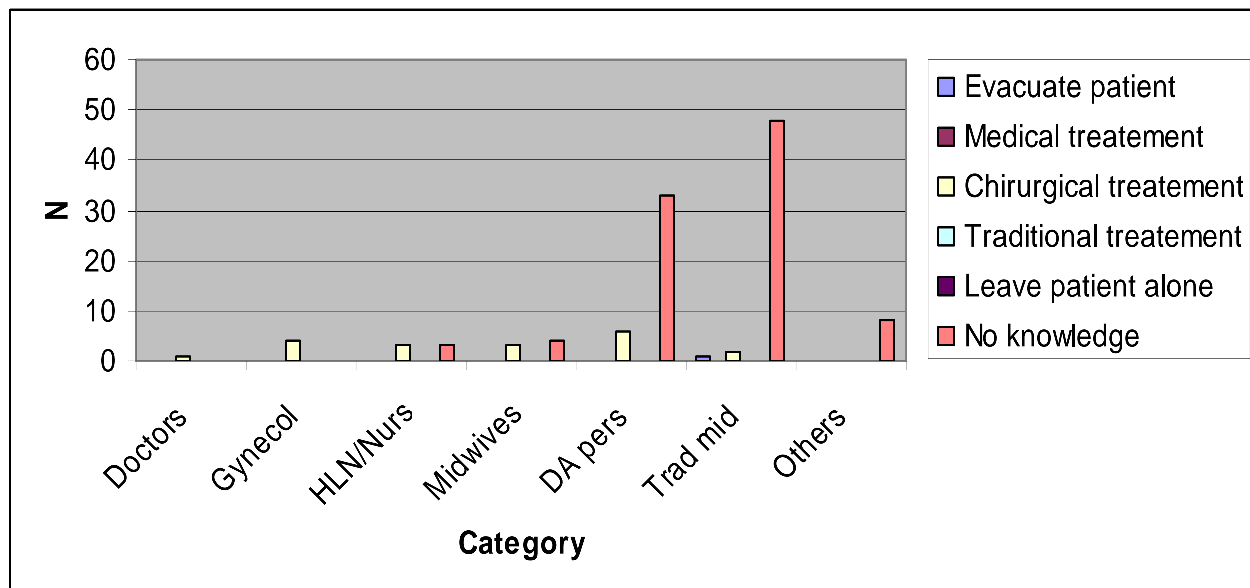
Besides, doctors, gynecologists, midwives and some high level nurses/nurses (13%) amounted to 15 persons which have well knowledge on the causes of obstetric fistula. The reinforcement on Information and training process of support and health personnel on obstetric fistula should be one of the priorities of the sensitization plan of health personnel and the entire community to eliminate obstetric fistula in Equatorial Guinea up to 2020.

TABLE 6:

KNOWLEDGE LEVEL OF HEALTH PERSONNEL ON HANDLING PROCESS OF OBSTETRIC FISTULA (JUNE 2005)

HANDLING POSSIBILITIES	HEALTH PERSONNEL							TOTAL
	Doctors	Gynecol	HLN/Nurs	Midwives	DA pers	Trad mid	Others	
Evacuate patient	0	0	0	0	0	1	0	*1*
Medical treatement	0	0	0	0	0	0	0	*0*
Chirurgical treatement	1	4	3	3	6	2	0	*19*
Traditional treatement	0	0	0	0	0	0	0	*0*
Leave patient alone	0	0	0	0	0	0	0	*0*
No knowledge	0	0	3	4	33	48	8	*96*
TOTAL	***1***	***4***	***6***	***7***	***39***	***51***	***8***	***116***

GRAPHIC 6: KNOWLEDGE LEVEL OF HEALTH PERSONNEL ON HANDLING PROCESS OF OBSTETRIC FISTULA (JUNE 2005)



Comments :

Most of the delivery assistance interviewed personnel had no knowledge on handling process of obstetric fistula (83%) amounted to 96 cases, the delivery auxiliar personnel and traditional midwives persisted (81 cases) which represents 70% of the total delivery assistance personnel at national level. Meanwhile, those who have full knowledge on handling process of obstetric fistula were 19 effectifs (16%). In this group, doctors, gynecologists, some high level nurses/nurses and midwives are 11 cases (9%).

This situation shows the evidence of the high number of cases of obstetric fistula, even the deliveries are institutionals and manifests clearly that when somone has no information on something cannot prevent or treate its consequences. The training

of health personnel, Information, Education and Communication (IEC) agents and traditional midwives on obstetric and neonatology cares is presented as a necessity to improve maternal health and eliminate obstetric fistula in Equatorial Guinea.

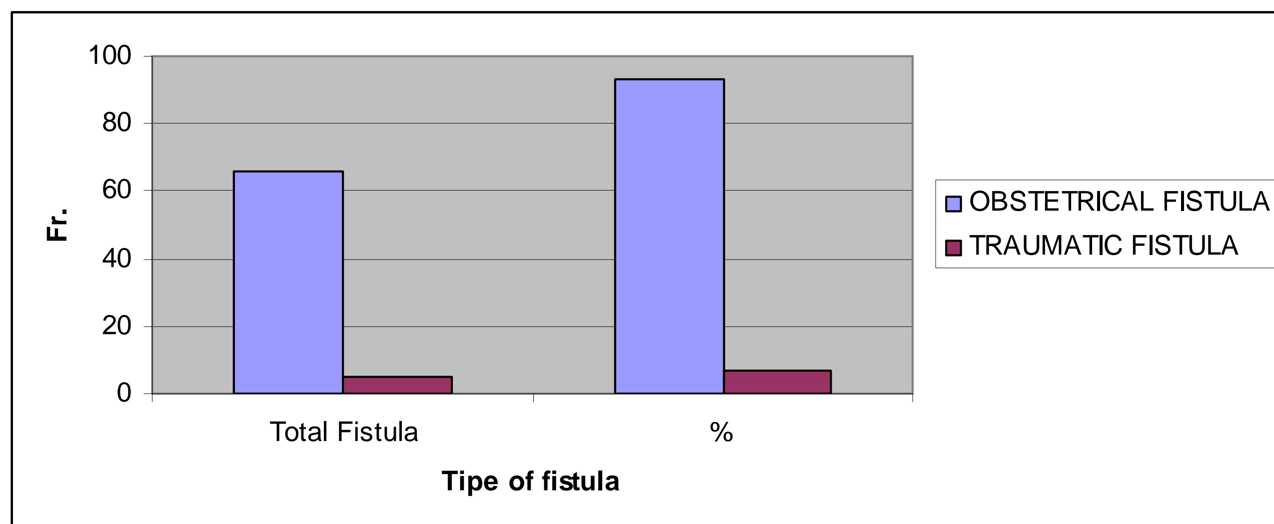
(iii). Situation of women living with obstetric fistula.

TABLE 7:

DISTRIBUTION OF WOMEN IDENTIFIED AS LIVING WITH OBSTETRIC FISTULA ACCORDING TO AETIOLOGY (JUNE 2005)

TIPE OF FISTULA	Total Fistula	%
OBSTETRICAL FISTULA	66	93
TRAUMATIC FISTULA	5	7
TOTAL	**71**	**100**

GRAPHIC 7
DISTRIBUTION OF WOMEN IDENTIFIED AS LIVING WITH FISTULA ACCORDING TO AETIOLOGY (JUNE 2005)



Comments:

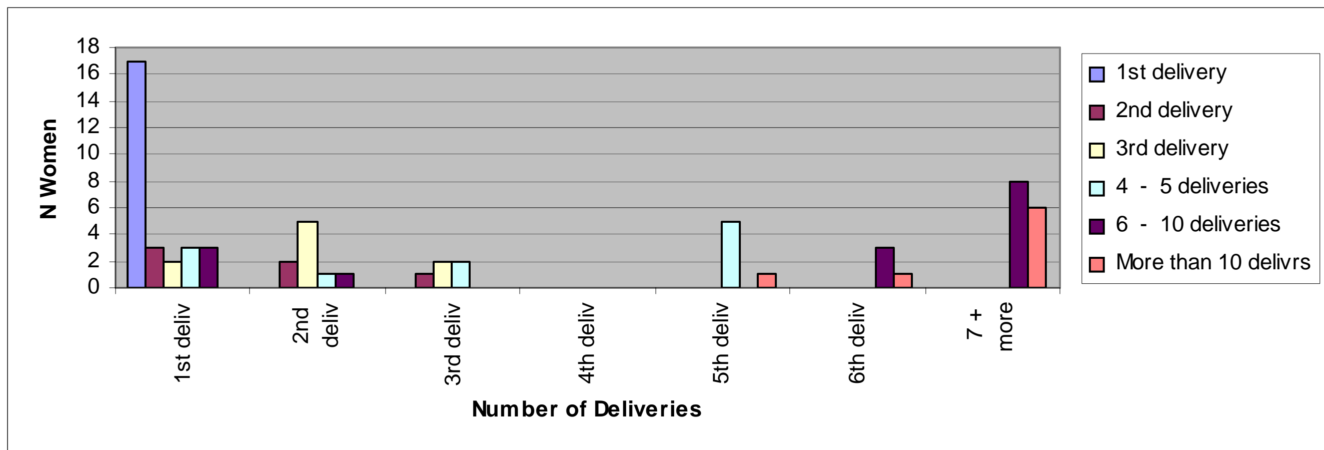
This table shows that 93% of identified obstetric fistula (66 cases) corresponds to the symptomathology of obstetric fistula against a 3% atributable to traumatic fistula (5 cases), found on non delivered women. These traumatic fistula are caused by provoqued abortions, violence and sexual traumatisms within low age girls and bad terapeutical practices. Consequently it is recommended that the adoption and application of protective measures to young girls be adopted to waranty its integrated development in the community.

TABLE 8:

DISTRIBUTION OF WOMEN IDENTIFIED AS LIVING WITH OBSTETRIC FISTULA ACCORDING TO THE NUMBER OF BIRTHS AND DELIVERY LEVEL AT THE APPARITION OF FISTULA (JUNE 2005)

CHILDBIRTHS	LEVEL OF DELIVERY DURING APPEARANCE OF FISTULA							TOTAL
	1st deliv	2nd deliv	3rd deliv	4th deliv	5th deliv	6th deliv	7 + more	
1st delivery	17	0	0	0	0	0	0	17
2nd delivery	3	2	1	0	0	0	0	6
3rd delivery	2	5	2	0	0	0	0	9
4 - 5 deliveries	3	1	2	0	5	0	0	11
6 - 10 deliveries	3	1	0	0	0	3	8	15
More than 10 delivrs	0	0	0	0	1	1	6	8
TOTAL GENERAL	28	9	5	0	6	4	14	66

GRAPHIC 8:
DISTRIBUTION OF WOMEN IDENTIFIED AS LIVING WITH FISTULA, ACCORDING TO THE NUMBER OF BIRTHS AND DELIVERY LEVEL AT THE APPARITION OF THE FISTULA (JUNE 2005)



Comments:

Most of the obstetric fistulas took place during the first delivery, amounted to 28 cases (39%) being primiparous the most affected group, with 17 cases (24%) follwed by multiparous after the seventh delivery, with 14 cases (20%). The lack of attendance of deliveries, specially by primiparous has the consequence of a high number of obstetric fistulas after the first delivery (39%); also the same situation appears with multiparous (24%) which coincide with that stated in the report regarding the causes and the period of appearance of the obstetric fistulas.

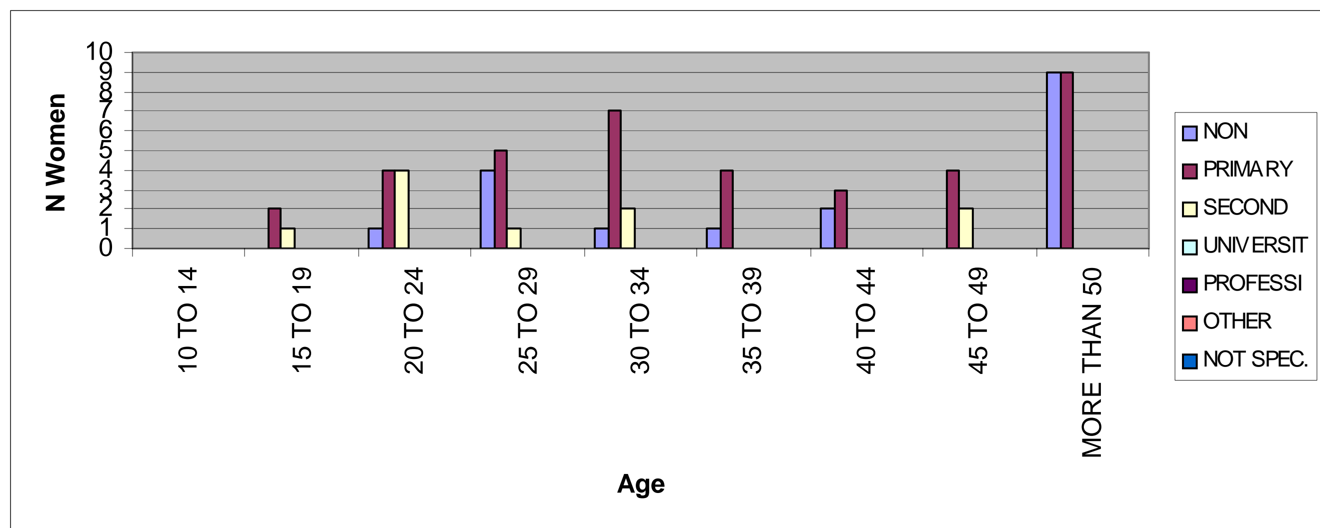
Special attention should be drawn to reinforce the follow up actions on pregnancies and parturients during the delivery, specially primiparous and multiparous where most of the complications are often and cases most of the obstetric fistulas.

TABLE 9 :

DISTRIBUTION OF WOMEN IDENTIFIED AS LIVING WITH OBSTETRIC FISTULAS ACCORDING TO THE AGE AND LEVEL OF INSTRUCTION (JUNE 2005)

AGE (Years)	INSTRUCTION LEVEL							TOTAL
	NON	PRIMARY	SECOND	UNIVERSIT	PROFESSI	OTHER	NOT SPEC.	
10 TO 14	0	0	0	0	0	0	0	***0***
15 TO 19	0	2	1	0	0	0	0	***3***
20 TO 24	1	4	4	0	0	0	0	***9***
25 TO 29	4	5	1	0	0	0	0	***10***
30 TO 34	1	7	2	0	0	0	0	***10***
35 TO 39	1	4	0	0	0	0	0	***5***
40 TO 44	2	3	0	0	0	0	0	***5***
45 TO 49	0	4	2	0	0	0	0	***6***
MORE THAN 50	9	9	0	0	0	0	0	***18***
TOTAL GENERAL	***18***	***38***	***10***	***0***	***0***	***0***	***0***	***66***

GRAPHIC 9:
DISTRIBUTION OF WOMEN IDENTIFIED AS LIVING WITH OBSTETRIC FISTULA, ACCORDING TO THE AGE AND INSTRUCTION LEVEL (JUNE 2005)



Comments:

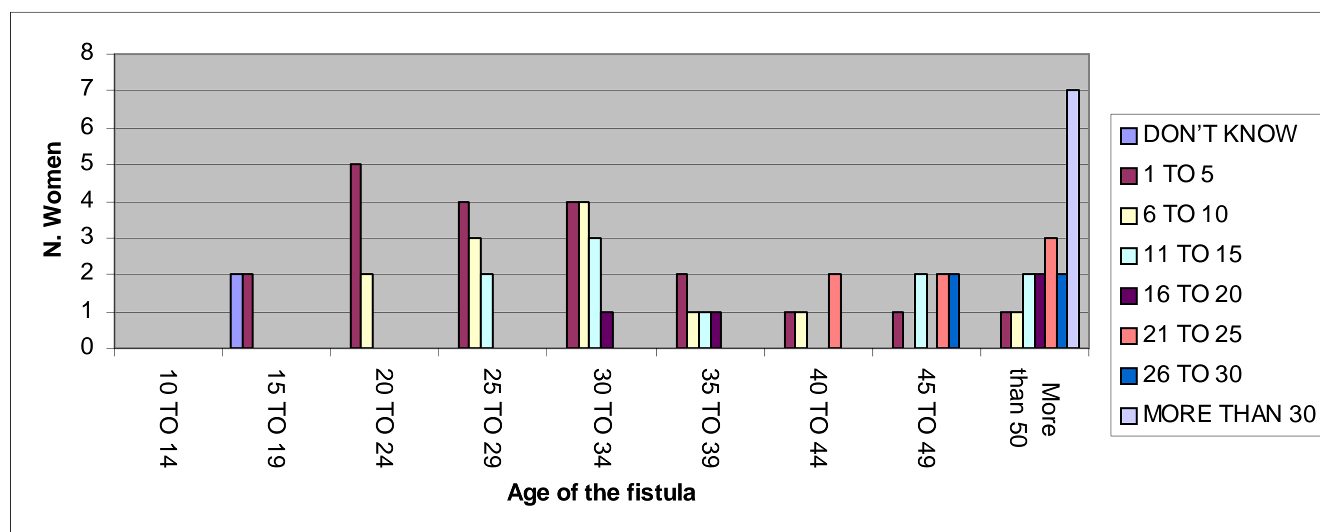
The total number of women living with fistula had an instruction level less than the secondary, with 56 cases (85%), most of them at primary level and who has no level. It is important to note that data for the instruction level have not been collected by grade, this makes difficult to determine if the declared level corresponds to the reality (title and study diploma). On the other hand,reviewing the replies received from such women in other questions it is stated that the declared level does not corresponds to the secondary, but to the primary level. In this case, it is recommended the reinforcement of the iliteracy campaigns and the sentisisation of the population, specially women at birth age.

TABLE 10 :

DISTRIBUTION OF WOMEN LIVING WITH OBSTETRIC FISTULA ACCORDING TO THE AGE AND THE ANCIANITY OF THE FISTULA (JUNE 2005)

AGE (YEARS)	AGE OF THE FISTULA (YEARS)								TOTAL
	DON'T KNOW	1 TO 5	6 TO 10	11 TO 15	16 TO 20	21 TO 25	26 TO 30	MORE THAN 30	
10 TO 14	0	0	0	0	0	0	0	0	0
15 TO 19	2	2	0	0	0	0	0	0	4
20 TO 24	0	5	2	0	0	0	0	0	7
25 TO 29	0	4	3	2	0	0	0	0	9
30 TO 34	0	4	4	3	1	0	0	0	12
35 TO 39	0	2	1	1	1	0	0	0	5
40 TO 44	0	1	1	0	0	2	0	0	4
45 TO 49	0	1	0	2	0	2	2	0	7
More than 50	0	1	1	2	2	3	2	7	18
TOTAL	**2**	**20**	**12**	**10**	**4**	**7**	**4**	**7**	**66**

GRAPHIC 10:
DISTRIBUTION OF WOMEN WITH FISTULA, ACCORDING TO THE AGE AND THE ANCIANITY OF THE FISTULA (JUNE 2005)



Comments:

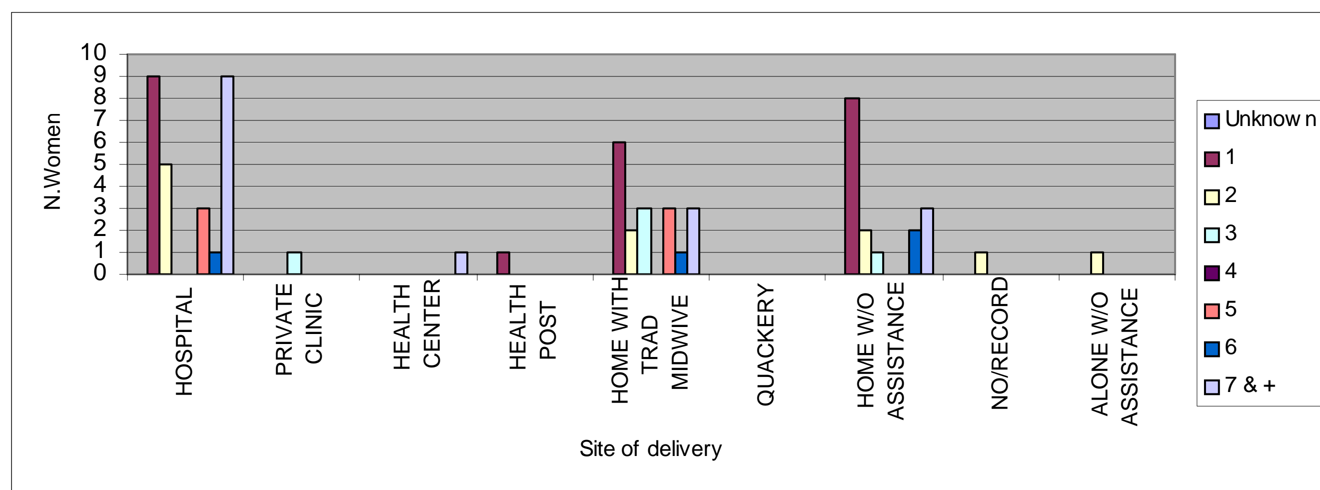
The lack of knowledge of women living with fistula on obstetric fistula makes that the majority of them lives with the desease for several years, for exemple, from 1 to 5 years fistula with 20 cases (30%), 6 to 10 years and 11 to 15 years with 22 cases (33%). With regard to the age it is noted that the major number of fistulas ocurred between the ages of 15 to 39 years, with 32 cases (48%) and that confirm that generally obstetric fistula cases occurred very often after the first delivery. So that it is propossed that this group be pioritary during the next campaign of reparation of obstetric fistulas due to the fact that this is the group of women that is in fertility age.

TABLE 11:

DISTRIBUTION OF WOMEN LIVING WITH OBSTETRICAL FISTULA, ACCORDING TO THE NUMBER OF DELIVERIES AND SITE OF DELIVERY (JUNE 2005)

SITE OF DELIVERY	NUMBER OF DELIVERIES								TOTAL
	Unknown	1	2	3	4	5	6	7 & +	
HOSPITAL	0	9	5	0	0	3	1	9	27
PRIVATE CLINIC	0	0	0	1	0	0	0	0	1
HEALTH CENTER	0	0	0	0	0	0	0	1	1
HEALTH POST	0	1	0	0	0	0	0	0	1
HOME WITH TRAD MIDWIVE	0	6	2	3	0	3	1	3	18
QUACKERY	0	0	0	0	0	0	0	0	0
HOME W/O ASSISTANCE	0	8	2	1	0	0	2	3	16
NO/RECORD	0	0	1	0	0	0	0	0	1
ALONE W/O ASSISTANCE	0	0	1	0	0	0	0	0	1
TOTAL	**0**	**24**	**11**	**5**	**0**	**6**	**4**	**16**	**66**

GRAPHIC 11: DISTRIBUTION OF WOMEN LIVING WITH OBSTETRIC FISTULAS, ACCORDING TO THE NUMBER OF DELIVERIES AND SITE OF DELIVERY (JUNE 2005)



Comments:

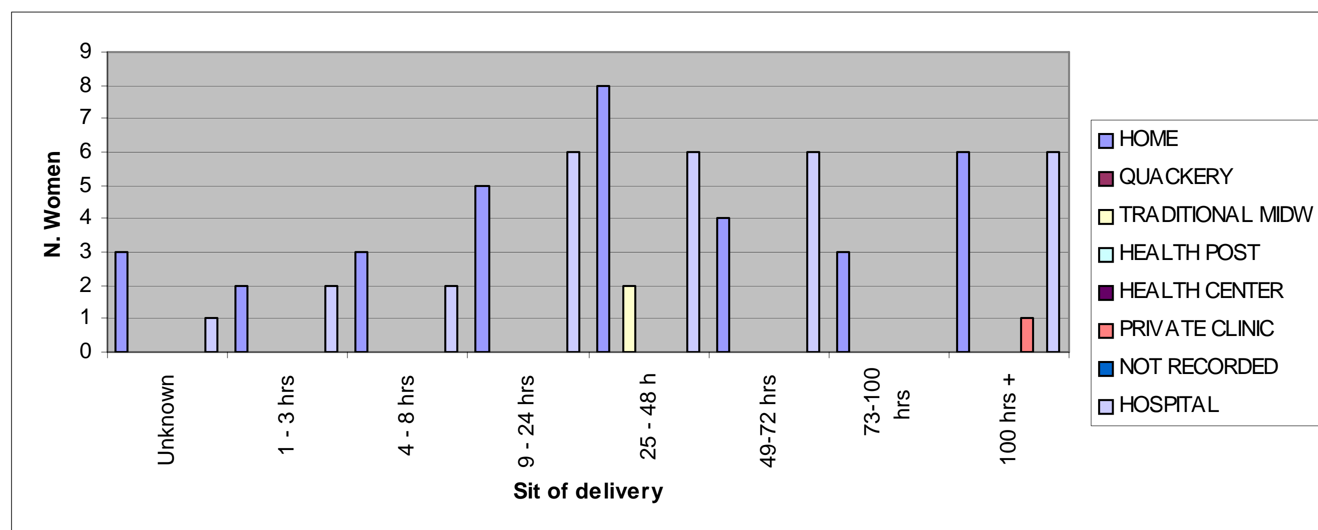
This table indicates that the low geographic access of women to health services due to the low functioning of the primary health cares, poverty of many families and the lack of information of the population makes that most of the deliveries be conducted without any assistance, with 16 cases (34%), followed by the deliveries conducted at homes assisted by traditional midwives, with 27 cases (27%) ended by deliveries carried out in hospitals, 27 cases (40%). Therefore, it is concluded that the only way to decrease the incidence of obstetrical fistula will be the increasing of institutional deliveries (institutional delivery means that any delivery conducted in a hospital or health center).

TABLE 12:

DISTRIBUTION OF WOMEN LIVING WITH OBSTETRIC FISTULA ACCORDING TO THE SITE AND DURATION OF DELIVERY (JUNE 2005)

SITE OF DELIVERY	DURATION OF THE DELIVERY								
	Unknown	1 - 3 hrs	4 - 8 hrs	9 - 24 hrs	25 - 48 h	49-72 hrs	73-100 hrs	100 hrs +	TOTAL
HOME	3	2	3	5	8	4	3	6	34
QUACKERY	0	0	0	0	0	0	0	0	0
TRADITIONAL MIDW	0	0	0	0	2	0	0	0	2
HEALTH POST	0	0	0	0	0	0	0	0	0
HEALTH CENTER	0	0	0	0	0	0	0	0	0
PRIVATE CLINIC	0	0	0	0	0	0	0	1	1
NOT RECORDED	0	0	0	0	0	0	0	0	0
HOSPITAL	1	2	2	6	6	6	0	6	29
GRAND TOTAL	4	4	5	11	16	10	3	13	66

GRAPHIC 12: DISTRIBUTION OF WOMEN LIVING WITH OBSTETRIC FISTULA, ACCORDING TO THE SITE AND DURATION OF THE DELIVERY (JUNE 2005)



Comments:

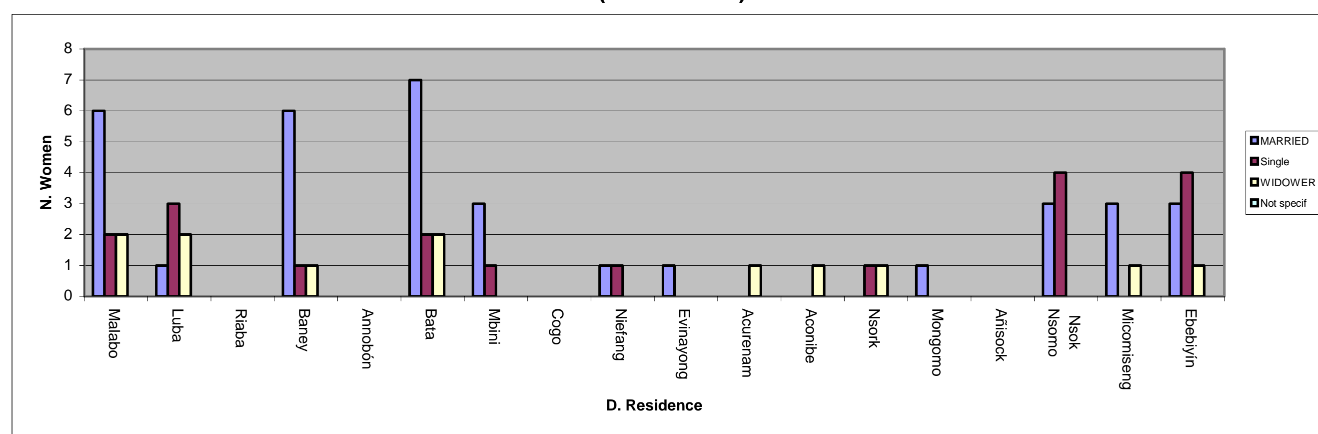
Most of the fistula took place in women which delivery delayed more than 25 to 48 hours with 18 cases (24%), followed by deliveries delayed more than 100 hours with 13 cases (19%). That demonstrates that delayed delivery operations had a great incidence in obstetric fistula. Hence, the first idea is reinforced to increase progressively institutional deliveries, with strong recommendation that the delivery assistance personnel be trained on the duration and evolution of deliveries (i.e.: multiparous delivery duration does not exceed 8 to 12 hours; primiparous should not exceed 12 to 15 hours). As a suggestion, the use of parthogramme to ensure follow up on parturients during deliveries should apply.

TABLE 13:

DISTRIBUTION OF WOMEN IDENTIFIED AS LIVING WITH OBSTETRIC FISTULA ACCORDING TO THE DISTRICT OF RESIDENCE AND THEIR CIVIL STATUS (JUNE 2005)

DISTRICT OF RESIDENCE	WOMEN'S CIVIL STATUS				TOTAL
	MARRIED	Single	WIDOWER	Not specif	
Malabo	6	2	2	0	10
Luba	1	3	2	0	6
Riaba	0	0	0	0	0
Baney	6	1	1	0	8
Annobón	0	0	0	0	0
Bata	7	2	2	0	11
Mbini	3	1	0	0	4
Cogo	0	0	0	0	0
Niefang	1	1	0	0	2
Evinayong	1	0	0	0	1
Acurenam	0	0	1	0	1
Aconibe	0	0	1	0	1
Nsork	0	1	1	0	2
Mongomo	1	0	0	0	1
Añisock	0	0	0	0	0
Nsok Nsomo	3	4	0	0	7
Micomiseng	3	0	1	0	4
Ebebiyín	3	4	1	0	8
TOTAL	***35***	***19***	***12***	***0***	***66***

GRAPHIC 13 : DISTRIBUTION OF WOMEN IDENTIFIED AS LIVING WITH OBSTETRIC FISTULA, ACCORDING TO DISTRICT OF RESIDENCE AND CIVIL STATUS (JUNIO 2005)



Comments:

The fact that most of fistula cases be on married women 35 cases (53%), is justified not only because that marriage waranties familiar descendency by having much children, but most marriages are precocious and leads to deliveries at homes due to the fact that first birth should be at home (with grandmothers). This coincide with data of the survey. Fistulas in single women, 19 cases (29%) and with widowers, 12 cases (18%) respectively are justified because of the lack of economical ressources of the families which allows women to benefit from an assisted delivery in a hospital and by trained personnel.

Discriminatory family and social situations lead women with fistula to hide themselves, even farther from their usual environments, as well as to look for a solution dealing with their fistula situations. Makes them also lives in cities as Malabo and Bata, with 10 and 11 cases, respectivelly. It is recommended to carry out the necessary advocacy actions to mobilize the

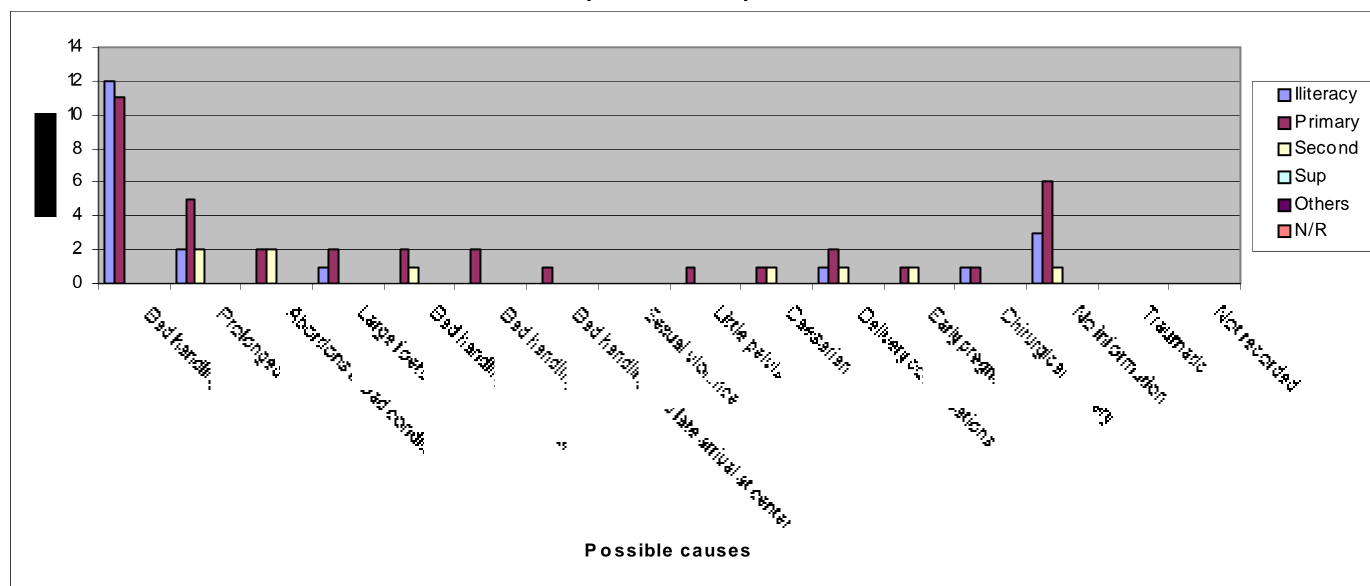
appropriate resources in order to repair cases identified with fistula and the socioeconomical reinsertion of affected women in Equatorial Guinea.

TABLE 14:

KNOWLEDGE OF THE CAUSES OF OBSTETRIC FISTULA, ACCORDING TO WOMEN'S LEVEL OF INSTRUCTION (JUNE 2005)

POSSIBLE CAUSES	INSTRUCTION LEVEL						TOTAL
	Iliteracy	Primary	Second	Sup	Others	N/R	
Bad handling	12	11	0	0	0	0	23
Prolonged delivery	2	5	2	0	0	0	9
Abortions in bad conditions	0	2	2	0	0	0	4
Large foetus	1	2	0	0	0	0	3
Bad handling and prolonged delivery	0	2	1	0	0	0	3
Bad handling of tools	0	2	0	0	0	0	2
Bad handling and late arrival at center	0	1	0	0	0	0	1
Sexual violence	0	0	0	0	0	0	0
Little pelvis	0	1	0	0	0	0	1
Caesarian	0	1	1	0	0	0	2
Delivery complications	1	2	1	0	0	0	4
Early pregnancy	0	1	1	0	0	0	2
Chirurgical delivery	1	1	0	0	0	0	2
No information	3	6	1	0	0	0	10
Traumatic	0	0	0	0	0	0	0
Not recorded	0	0	0	0	0	0	0
TOTAL	***20***	***37***	***9***	***0***	***0***	***0***	***66***

GRAPHIC 14: CAUSE KNOWLEDGE ON OBSTETRIC FISTULA, ACCORDING TO WOMEN'S INSTRUCTION LEVEL (JUNE 2005).



Comments:

Inspite of womes's low level of instructions, and the lack of information on obstetric fistula, the possible causes identified by themselves as being responsible of the fistula, through a series of questions, corresponds, in most cases, to real causes (prolonged deliveries, bad use of tools, etc.) where the bad use of tools during delivery 23 cases (35%), appears as the main cause, followed by prolonged deliveries 9 cases (14%). However, the training and sensitization of womens on maternal health as well as on fistula concerns, should be reinforced in order to find out in appropriate moments all alert signs of delivery complications which lead to obstetric fistula.

TABLE 15:

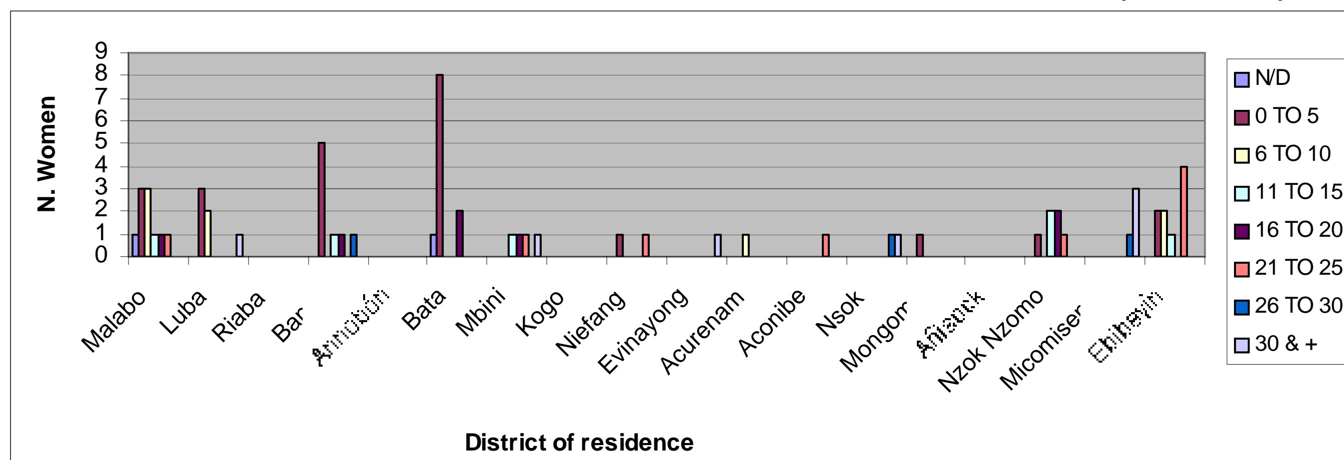
DISTRIBUTION OF WOMEN WITH OBSTETRIC FISTULA ACCORDING TO THE DISTRICT OF RESIDENCE AND DISTANCE FROM THE NEAREST HEALTH CENTER (JUNE 2005)

LOCATIONS	DISTANCE (KMS) TO THE NEAREST HEALTH CENTER								TOTAL
	N/D	0 TO 5	6 TO 10	11 TO 15	16 TO 20	21 TO 25	26 TO 30	30 & +	
Malabo	1	3	3	1	1	1	0	0	**10**
Luba	0	3	2	0	0	0	0	1	**6**
Riaba	0	0	0	0	0	0	0	0	**0**
Baney	0	5	0	1	1	0	1	0	**8**
Annobón	0	0	0	0	0	0	0	0	**0**
Bata	1	8	0	0	2	0	0	0	**11**
Mbini	0	0	0	1	1	1	0	1	**4**
Kogo	0	0	0	0	0	0	0	0	**0**
Niefang	0	1	0	0	0	1	0	0	**2**
Evinayong	0	0	0	0	0	0	0	1	**1**
Acurenam	0	0	1	0	0	0	0	0	**1**
Aconibe	0	0	0	0	0	1	0	0	**1**
Nsok	0	0	0	0	0	0	1	1	**2**
Mongomo	0	1	0	0	0	0	0	0	**1**
Añisock	0	0	0	0	0	0	0	0	**0**
Nzok Nzomo	0	1	0	2	2	1	0	0	**6**
Micomiseng	0	0	0	0	0	0	1	3	**4**
Ebibeyín	0	2	2	1	0	4	0	0	9
TOTAL	***2***	***24***	***8***	***6***	***7***	***9***	***3***	***7***	***66***

ND = No data.

GRAPHIC 15:

DISTRIBUTION OF WOMEN WITH OBSTETRIC FISTULA, ACCORDING TO THE DISTRICT OF RESIDENCE AND DISTANCE FROM THE NEAREST HEALTH CENTER (JUNE 2005).



Comments:

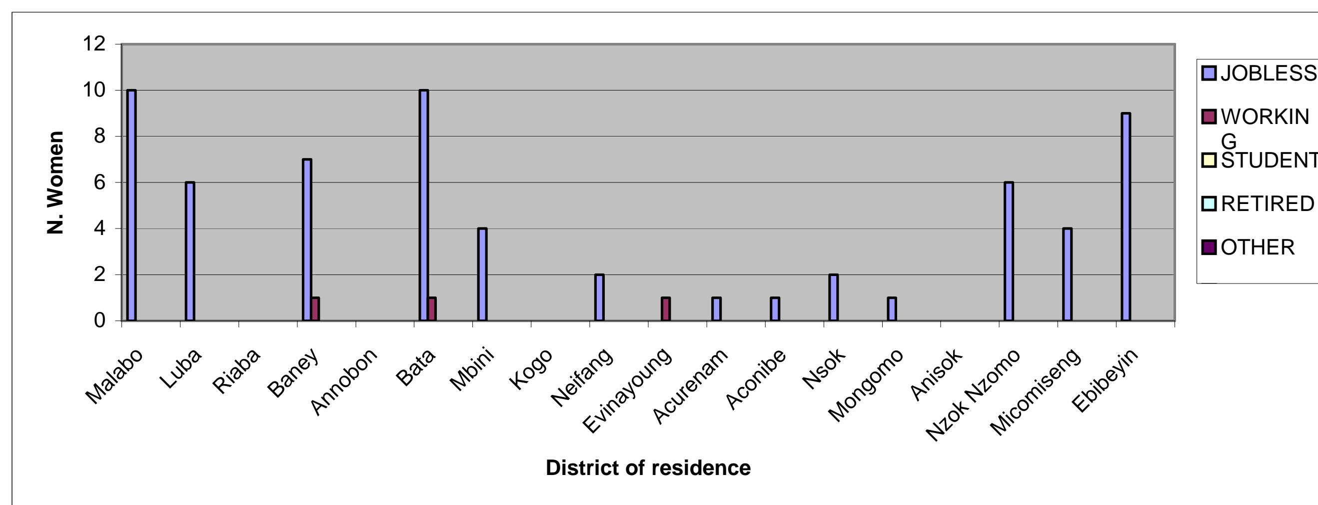
The distance analysis shows that nearly half of women with obstetric fistula lives within a ratio of 5 km with 24 cases (36%), this distance is acceptable for the use of available health services. The lack of knowledge by these women of alert signs on deliveries, the negative influence from traditional practices, the low assistance form their spouses, the poverty of their families and the low competence of the personnel attending deliveries, etc. justifies this situation. A 21% of women with fistula lives at a 6 to 15 km far from the nearest health center, situation which is related to the deficiency of functioning of the primary health cares, where community agents and traditional midwives should play an important role to attend deliveries and the early transfer of the most complicated cases. In this basis, it is necessary to reinforce the primary health cares at district level to increase the rate of assisted deliveries, stablishing a link between both primary and secondary level of health care.

TABLE 16:

DISTRIBUTION OF WOMEN WITH OBSTETRIC FISTULA ACCORDING TO DISTRICT OF RESIDENCE AND OCCUPATIONAL SITUATION (JUNE 2005)

DISTRICT OF RESIDENCE	OCCUPATIONAL SITUATION						TOTAL
	JOBLESS	WORKING	STUDENT	RETIRED	OTHER	REMARKS	
Malabo	10	*0*	*0*	*0*	*0*	*0*	**10**
Luba	6	*0*	*0*	*0*	*0*	*0*	**6**
Riaba	0	*0*	*0*	*0*	*0*	*0*	**0**
Baney	7	*1*	*0*	*0*	*0*	*0*	**8**
Annobon	0	*0*	*0*	*0*	*0*	*0*	**0**
Bata	10	*1*	*0*	*0*	*0*	*0*	**11**
Mbini	4	*0*	*0*	*0*	*0*	*0*	**4**
Kogo	0	*0*	*0*	*0*	*0*	*0*	**0**
Neifang	2	*0*	*0*	*0*	*0*	*0*	**2**
Evinayoung	0	*1*	*0*	*0*	*0*	*0*	**1**
Acurenam	1	*0*	*0*	*0*	*0*	*0*	**1**
Aconibe	1	*0*	*0*	*0*	*0*	*0*	**1**
Nsok	2	*0*	*0*	*0*	*0*	*0*	**2**
Mongomo	1	*0*	*0*	*0*	*0*	*0*	**1**
Anisok	0	*0*	*0*	*0*	*0*	*0*	**0**
Nzok Nzomo	6	*0*	*0*	*0*	*0*	*0*	**6**
Micomiseng	4	*0*	*0*	*0*	*0*	*0*	**4**
Ebibeyin	9	*0*	*0*	*0*	*0*	*0*	**9**
TOTAL	**63**	***3***	***0***	***0***	***0***	***0***	***66***

GRAPHIC 16: DISTRIBUTION OF WOMEN LIVING WITH OBSTETRIC FISTULAS, ACCORDING TO DISTRICT OF RESIDENCE AND OCCUPATIONAL SITUATION (JUNIO 2005).



Comments:

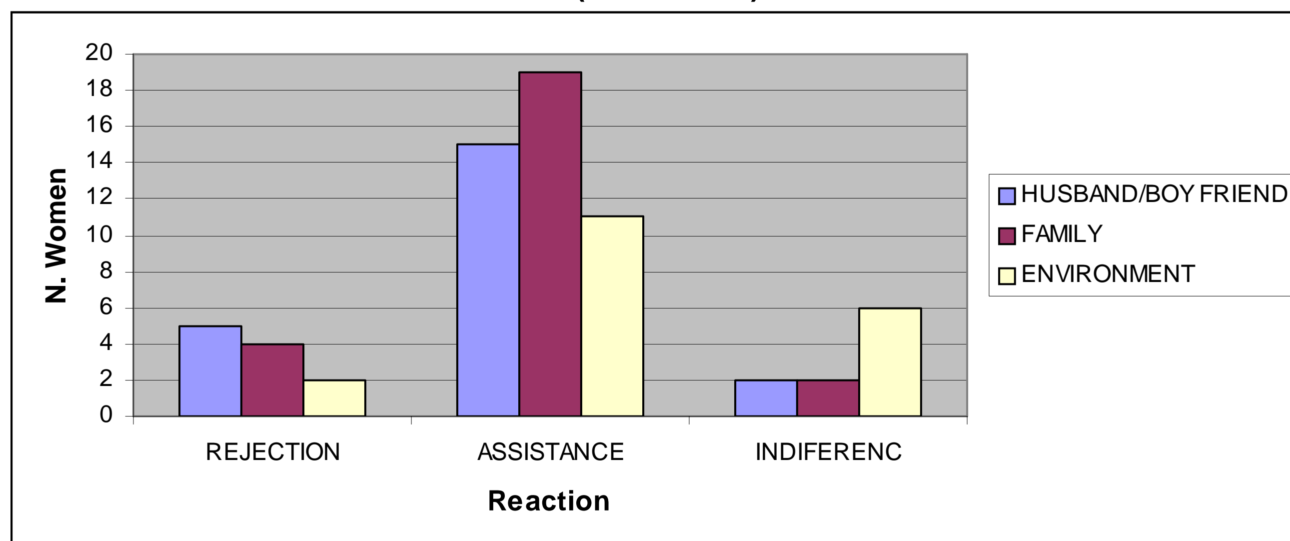
Most of the interviewed women identified with obstetric fistua were jobless, with 63 cases (95%) due to low salaries at field level, even most of them were jobless. Nevertheless, their economical situation is still tight due to the fact that this dessease makes difficult their lifes to have a job as well as their social relations. In this case, it is recommended to ensure women psycosocial accompaniment as well as to develop advocacy activities to mobilize the necessary ressources in order to reduce poverty level and sensitization to the population on obstetric fistula as a result of bad delivery process, keeping in mind that obstetric fistula does not depend on women but from the social development level. It is suggested that after diagnosis of obstetric fistula a solution to retrieve their laboral and social status should be strongly found.

TABLE 17:

REACTIONS AGAINST WOMEN IDENTIFIED AS LIVING WITH OBSTETRIC FISTULA AT FAMILY AND COMMUNITY LEVEL (JUNE 2005)

RELATIONSHIP	REACTION			*TOTAL*
	REJECTION	ASSISTANCE	INDIFERENC	
HUSBAND/BOY FRIEND	5	15	2	*22*
FAMILY	4	19	2	*25*
ENVIRONMENT	2	11	6	*19*
GRAND TOTAL	*11*	*45*	*10*	*66*

GRAPHIC 17: REACTIONS AGAINST WOMEN WITH OBSTETRIC FISTULA AT COMMUNITY AND FAMILY LEVEL (JUNE 2005).



Comments:

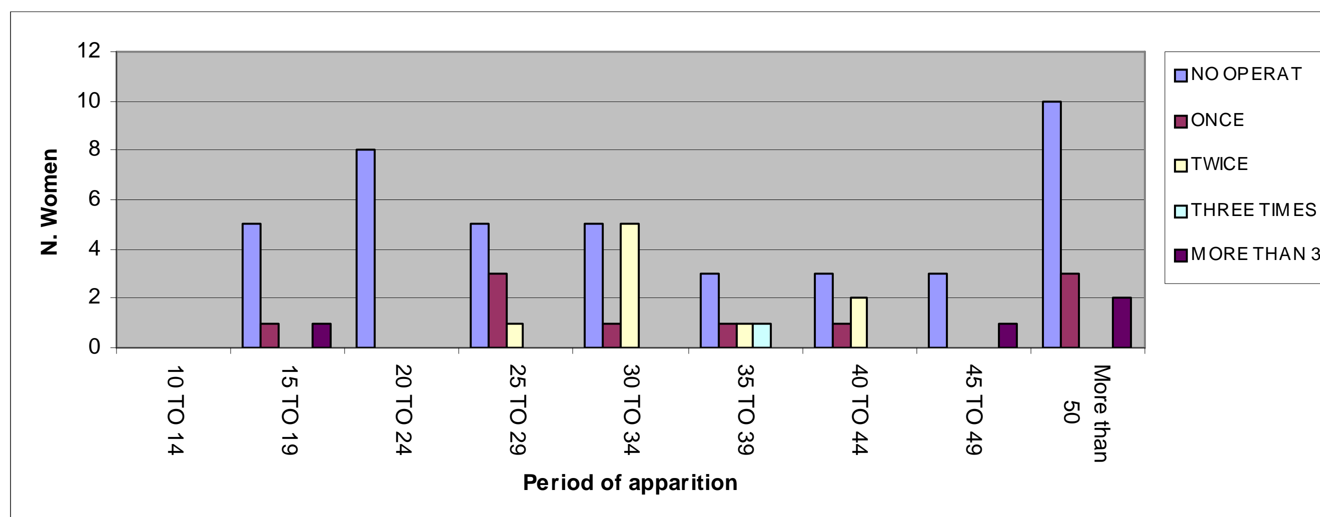
Inspite of the humanitarian character of the african society, it is observed that from the 66 women identified wit obstetric fistula, 11 were rejected by their relatives 917%), 45 received assistance from their families (68%) while only in 10 women it were noted a great indifference (15%) by the overall environment. Rejection means a relation with the familiar influence in their homes, as well as the sociocultural and economical level of the husband and their family. In view of these results, it is recommended to reinforce IEC activities toward the overall community, and, particularly at local and basic community levels as well as women associations to promote and protect women's rights, specially, sexual and reproducive rights in order to empower solidarity, mutual comprehention at family and community level, avoiding any type of rejection to women with obstetric fistula.

TABLE 18:

FAILURES NOTED ON MEDICAL TREATMENTS ACCORDING TO AGE OF WOMEN AND NUMBER OF OBSTETRIC FISTULA REPARATIONS (JUNE 2005)

AGE OF FISTULA ON WOMEN (YEARS)	NUMBER OF FAILURES ON REPARATION					TOTAL
	NO OPERAT	ONCE	TWICE	THREE TIMES	MORE THAN 3	
10 TO 14	0	0	0	0	0	0
15 TO 19	5	1	0	0	1	7
20 TO 24	8	0	0	0	0	8
25 TO 29	5	3	1	0	0	9
30 TO 34	5	1	5	0	0	11
35 TO 39	3	1	1	1	0	6
40 TO 44	3	1	2	0	0	6
45 TO 49	3	0	0	0	1	4
More than 50	10	3	0	0	2	15
	42	***10***	***9***	***1***	***4***	***66***

GRAPHIC 18:
FAILURES NOTED ON MEDICAL TREATMENTS ACCORDING TO AGE AND NUMBER OF REPARATIONS OF OBSTETRIC FISTULA (JUNIO 2005).



Comments:

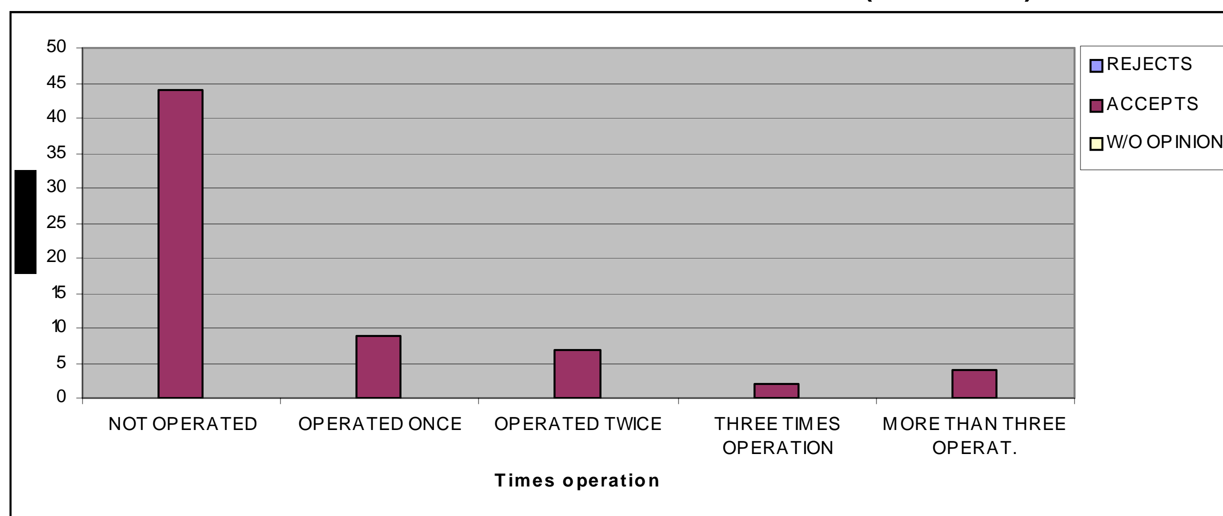
Due to economical defficiencies, the lact of obstetric fistula repair centers as well as qualified personnel in Equatorial Guinea, the lack of information of women themselves on obstetric fistula reparation possibilities the negative influence of quackeries, makes that the major number of obstetric fistula cases were not surgically operated, with 47 cases (71%). Nevertheless, they have been cases of therapeutic failures, some of them carried out abroad with 10 cases after the first operation (15%) 9 cases after the second operation (13%) and 5 cases with more than 2 operations (8%). These failures pointes out the team of obstetric fistula repair specialists on the ruling process, depending on each group of cases. In this basis, it is considered that operations of more than 2 times are often risky and difficult to recuperate. These data recommends the elaboration of a national plan of obstetric fistula repair, assisted technically by specialist on the matter.

TABLE 19:

OPINION OF WOMEN IDENTIFIED WITH OBSTETRIC FISTULA ON POSSIBLE REPARATION PROCESS (JUNE 2005)

FREQUENCY OF REPARATION	REACTIONS			TOTAL
	REJECTS	ACCEPTS	W/O OPINION	
NOT OPERATED	0	44	0	*44*
OPERATED ONCE	0	9	0	*9*
OPERATED TWICE	0	7	0	*7*
THREE TIMES OPERATION	0	2	0	*2*
MORE THAN THREE OPERAT.	0	4	0	*4*
TOTAL GENERAL	***0***	***66***	***0***	***66***

GRAPHIC 19: OPINIONS OF WOMEN WITH OBSTETRIC FISTULA ON POSSIBLE REPARATION PROCESS (JUNE 2005).



Comments:

Data of this table reveals that 100% of interviewed women with obstetric fistula accepted to be operated, women not operated 44 cases (67%) are also notorial. With regad to already operated women it is observed that 14% of them have already operated once, 14% twice, 11% and 9%, more than 2 operations. This situation determines the sentsitization already made to the population, most particularly to women with obstetric fistula, as well as reparation possibilities and the gratuity of such reparations and social reinsertion with full participation of the families.

(v) Social Needs on prevention, reparation and social reinsertion after obstetric fistula operations.

Inspite of the existence of Information, Education and Communication (IEC) programmes to the population, on Reproductive Health aspects, data from the survey reflects the lack of information on Essential Obstetric Cares (ESOC) and Emmergency Obstetric Cares (EMOC), particularly on obstetric fistula in terms of basic knowledges in order to respond to social needs on prevention, reparation and social reinsertion after obstetric fistula operations in Equatorial Guinea.

To this end, advocacy activities toward the Government and its partners for the reparation and social reinsertion of women with obstetric fistula should be carried out as well as to promote sensitisation activities to health personnel on obstetric fistula, developping educative messages on essential obstetric cares and emmergency obstetric cares at community level.

VIII. MAIN CONCLUSSIONS

- At national level, the survey was conducted in all urban and rural areas around the country; as a result, 71 cases of fistula of which, 66 obstetric and 5 traumatic were found among women from 15 to 50 and more years old.
- Related to the capacity of health infrastructures for the management of obstetric fistula it is observed that regional hospitals of Bata and Malabo, including Loeri Comba Policlinic are well equiped and have qualified personnel who can help carry out reparation activities of obstetric fistula.
- Data from the 116 interviews revealed that the majority of assisted deliveries in Equatorial Guinea in 2005 were conducted by traditional midwives and delivery auxiliairy personnel, with 34 and 44%, respectively, and that this personnel has a professional experience of less than 20 years (78%).
- It is important to note that the majority of deliveries are conducted at parturients homes (51%) at post and health centers level (16%) by health agents and traditional midwives.
- 66% of delivery assistance personnel has no knowledge on obstetric fistula and that 75% of the same personnel have no knowledge of the possible causes of obstetric fistula, neither its handling process (83%), and that delivery auxiliar personnel and traditional midwives with 81 cases represents 70% ot the overall interviewed personnel handling deliveries at national level.
- Major number of obstetric fistula occurred after the first delivery (39%) by primiparous (24%) with an ancianity of 1 to 5 years (28%).
- Majority of women with obstetric fistula have 4 or more deliveries.
- Total women with obstetric fistula have an instruction level up to secondary (100%) those who have lower instruction level are the most important group. It is also noted that the most important rate of obstetric fistula corresponded to women with 15 to 39 years old (53%).
- 60% of women with obstetric fistula conducted their deliveries out of health infrastructures, specially at homes with or without any techical assistance against a 40% of obstetric fistula on deliveries conducted in hospitals.

- Regarding the duration of deliveries, it is observed that the majority of women with obstetric fistula had a delivery duration between 2 and 48 hours, with 16 cases (24%) followed by those conducted for more than 100 hours, with 13 cases (19%). Besides, it is noted that 53% of women are married, followed by single women (29%) and widows (18%).

- The locations found with major number of obstetric fistula were mainly Bata and Malabo, followed by Baney, with 11, 10 and 8 cases, respectivelly.

- Revising the possible causes of obstetric fistula it is stated that 34% of interviewed people confirmed that the main cause of obstetric fistula was the bad handling process on deliveries as well as prolonged deliveries with 9 cases (14%). While 24 of the women with obstetric fistula (36%) confirmed that distance between their homes and the nearest health insfrastructures were 0 to 5 km, considering that this distance is acceptable due to the availability of health services in these areas; 21% of women with obstetric fistula lives at 6 to 15 km far from the nearest health structure.

- Related to labour links 63 of women with obstetric fistula (95%) were jobless women, adding to that, that 11 women (17%) were rejected by their families and the environment.

- Regarding women opinions to be operated after therapetic failures (reparation) data analysis revealed that 100% of interviewed women accepted operations highlithing those who have not been operated, with 44 cases (67%). Those who have been operated at least 14% of them have been operated once, 11%, twice, and 9% more than 2 operations.

IX. MAIN RECOMMENDATIONS

a) The reinforcement of Reproductive Health (RH) service coverage through the following activities:

- Reinforcement of the construction, rehabilitation and equipment programme of maternities, post and health centers in order to offer qualitative RH services and be accessible to the population and pregnant women.

- Redynamisation of the advanced strategy in the community for pre natal consultation (PNC), Information, Education and Communication (IEC) and family planning (FP) consultations in order to improve the utilisation of RH services by the population in rural and unaccessible areas.

- Improvement of transfer services to equip maternities on surgeon in order to conduct caesarian operations, to facilitate the transport of women with delivery complications and to extend communication links at different level of health pyramide.

b) Reinforcement of operative capacities of the post and health centers as well as maternities through the following activities:

- Provision of inputs (drugs and equipment) as well as the armonisation of purchase and distribution actions for RH products at different RH partners level.

- Training of personnel on obstetric cares to provide the ncessary staff to post, health centers and maternities to conduct deliveries and transfer delivery with complications to higher level stages.

- Selection, training and appointment of 120 midwives coming from the differents districts, up to 2010, in order to improve quality of Emmergency Obstetric Cares (EMOC) and reduce the apparition of obstetric fistula.

- Coordination and work agreement between the UNFPA assisted National Programme for Reproductive Health and the Bata Faculty of Medicine in order to participate actively in the utilisation and training of new students (47 students from the 6th level) to have improved outcomes on women's reproductive health in Equatorial Guinea.

- The development of advocacy activities toward the Ministry of Health and Social Welfare to an equtative distribution of health personnel as well as the motivation of this personnel to the sustainability of the availability of qualitative services.

- To organize training / recyclation activities of traditional midwives to promote home assisted deliveries in rural and non accessible areas.

c) To develop Information, Education and Communication (IEC) activities as well as an advocacy on Emmergency Obstetric Cares (EMOC) and obstetric fistula, through the following activities:

- Operationalisation of 18 IEC distrital teams to allow women and the families to recognize signs and alert symptoms and pregnancy complications and deliveries and to adopt responsible behaviours to avoid obstetric fistula.

- To prioritize advance strategy jointly between health and IEC agents in order to increase utilisation of ante natal consultation (ANC) services, family planning (FP) and information on fistula in terms of causes, cosequences and possibilities of treatment, through difussion of appropriate messages accessible to the population.

- Empowerment of counseilling in health centers and maternities to stabilize a real confidence between women and health personnel ensuring that women are accepting identification and reparation of obstetric fistula.

- To develop advocacy activities for the mobilisation of ressources to allow reparation and socialeconomic reinsertion of women after obstetric fistula reparations.

- Utilisation of all available communication media that can permit exhaustive detection of all existing and not yet identified fistula to seek for reparation.

d) To promote the stablishment of women groupes and associations to improve maternal health through the following activities:

- To support female and non governemental organisations (NGOs) to associate and join establishment of organisation for the transportation of obstetric emmergencies.

- To put at disposal of women organisations (groups and NGOs) media and modalities to permit the families, when necessary, in the payment of expenses regarding obstetric cares through a system of activities of generation of incomes (DJANGUE).

- Mobilisation of men to participate in the establishment of female organisations towards the promotion of Reproductive Health.

e) To warranty reparation and reinsertion of women after obstetric fistula reparations, through the following activities:

- The application of the elaborated obstetric fistula reparation protocol, including the mobilisation of a team of specialists on reparation of Addis Abeba and Nigeria to reinforce national teams of the regional hospitals of Malabo and Bata.

- The establishment of a psycosocial accompanying plan to facilitate social reinsertion of women after obstetric fistula operations.

ATTACHEMENTS:

Annex 1: **List and addresses of women identified with fistula**

Annex 2: **Protocol of treatement**

Annex 3: **Workplan**

Annex 4: **Data collection tools**

Annex 5: **Liste of the national survey team**

Annex 1:

LIST AND ADDRESSES OF WOMEN IDENTIFIED WITH FÍSTULA

NO	NAMES AND FAMILY NAMES	AGE (Years)	PLACE OF INTERVIEW	ADDRESS	
				VILLAGE/QUARTER	DISTRICT
1	ESTHER NCHAMA MBA	26	MALABO	MALABO	MALABO
2	PERPETUA NCHAMA EDU	39	MALABO	SANTA MARIA III	MALABO
3	MONICA MIKUE MBA	68	MALABO	CAMPO YAUNDE	MALABO
4	ADRIANA OCOMO MBA	35	MALABO	CAYDASA	MALABO
5	SERAFINA BONEQUE BALOPA	82	SAMPACA	SAMPAKA	MALABO
6	GUADALUPE AKUMU ONDO	18	ELA NGUEMA	ELA NGUEMA	MALABO
7	SANCHA ANGUE	40	MALABO	SEMU	MALABO
8	LOURDES MICHA MBA	20	SACRIBA	SACRIBA (BISOSO)	MALABO
9	MARIA ROSA BELOPE MOCHE	59	BASILE	BASILE BUBI	MALABO
10	MARIA LUISA NCOHO	20	MALABO	SEMU	MALABO
11	MARIA AURORA MUEBAKE	65	ELA NGUEMA	ELA NGUEMA	MALABO
12	BALBINA MARLES BOSOKA	50	BANEY	ZONA MEDIA	BANEY
13	CRISTINA VILACIAN SOPALE	49	BANEY	CASCO URBANO	BANEY
14	VICTORIA PUPU BELOPE	66	BANEY	ZONA MEDIA	BANEY
15	REGINA MPESO LOPETE	25	BARESO	BARESO	BANEY
16	MILAGROSA SIALO LOKA	34	BANEY	CAMPO YAUNDE	MALABO
17	MAGDALENA CHONI BELOPE	29	BANEY	ZONA BAJA	BANEY
18	MILAGROSA COMPANA BUEBOLOBO	45	BOSOSO	BOSOSO	BANEY
19	VIRTUDES BETA EJAPA	22	BASAKATO ESTE	BASAKATO ESTE	BANEY
20	ANGELINA CHALE WILI	54	BAHO BASUALA	BAHO BASUALA	BANEY
21	PILAR CUPE BOLEKIA	20	BANEY	ZONA BAJA	BANEY
22	TRINIDAD DORO MESABO	60	LUBA	MUSOLA	LUBA
23	CARMEN ERIMO MEIHLE	84	LUBA	BATETE	LUBA
24	GLORIA LOSEBA SANABA	34	LUBA	BARRIO LAS PALMAS	LUBA
25	MILAGROSA BICHUMO ROPE	34	LUBA	MOERI	LUBA
26	MARIA M. MUATICHE BIOBA	63	LUBA	MOERI	LUBA
27	GERUNDINA PITER JONSONG	26	BELEBU	BELEBU	LUBA
28	ENRIQUETA NCHAMA ALOGO	32	LUBA	BOMBE MORA	LUBA
29	LUCIA IDJABE	48	BOMUDI	LEA	BATA
30	CONSUELO NFUNDI	29	BOMUDI	BOMUDI	BATA
31	SABINA NCHAMA NDONG	18	BENVENE ESAWONG	MOSOK ESANGUI	BATA
32	MODESTA MANGUE	45	MERCADO GRANDE	MERCADO GRANDE	BATA
33	ANITA ANGONO ASUMU	70	TIKA ETEMBUE	TIKA ETEMBUE	BATA
34	PRISCA AKANG OBAMA	24	ONDOHA	ONDOHA	BATA
35	ROSALIA EYANG MBA	30	NKOLOMBONG	NKOLOMBONG	BATA
36	YOLANDA NZANG ESONO	23	MINKAN	MINKAN	BATA
37	ESCOLASTICA EFUA	17	NKOLOMBONG	NKOLOMBONG	BATA
38	SINFOROSA ASUMU NFUMU	40	BATA	ASOK ABUHU	EVINAYONG
39	LOURDES NGONDE MALOE	60	COMANDACHINA	COMANDACHINA	BATA
40	CATALINA MIKUE NSUE	80	ELONGLONG	ELONGLONG	MBINI
41	JOSEFINA NFUMU BACALE	58	BITICA SUR	BITICA SUR	MBINI
42	PILAR MBA ETUN	55	MANGALA	MANGALA	MBINI
43	MARIA NKARA NDONG	65	SENDJE I	SENDJE I	MBINI
44	ROSALIA EYUANA MBA	27	NFULESONG ESANGUI	NFULESONG ESANGUI	NIEFANG

NO	NAMES AND FAMILY NAMES	AGE (Years)	PLACE OF INTERVIEW	ADDRESS	
				VILLAGE/QUARTER	DISTRICT
45	MARIA ABESO ENSEMA	33	MONGO	MACHINDA	BATA
46	MARI CARMEN MIKUE NGUERE	50	NKUMEKIEN	NKUMEKIEN	BATA
47	MONTSERRAT NCHAMA	68	AYAESONG	AYAESONG	ACURENAM
48	CRISTINA ASUE SEA	55	ALUM OBUCK	ALUM OBUCK	ACONIBE
49	CONCEPCION BILOGO BIBANG	21	EKUAMEYENE	EKUAMEYEN	NSORCK
50	INES NDONG MEDJA	30	NSORK	MBAM CONCENTRADO	NSORCK
51	ANASTASIA OBIANG ENGONGA	61	MONGOMO	DIMBALA	MONGOMO
52	MARINA AKULABANG	25	AVANG ESATOP	AVANG ESATOP	NZOCKNZOMO
53	MILAGROSA MBASOGO MONGO	41	METAMESI CONCENT	METAMESI CONCENT	NZOCKNZOMO
54	PETRA OBONO BIBANG	37	CASCO URBANO	NZOCKNZOMO	NZOCKNZOMO
55	DARIA MAMA	28	ABIARA ESATOP	ABIARA ESATOP	NZOCKNZOMO
56	FAUSTA AKELE OBAMA	70	ECOWONG ESENG	ECOWONG ESENG	NZOCKNZOMO
57	CRISTINA ALENE ONA	24	MBOMO ESABOCK	MBOMO ESABOCK	NZOCKNZOMO
58	TECLA ANDEME NSUE	30	COMUNIDA ZONA B	COMUNIDAD ZONA B	NZOCKNZOMO
59	MARIA AYINGONO	78	MBAM ESMONGON	MBAM ESAMONGON	MIKOMISENG
60	ROSALIA NCONO MONSUY	30	AFANEBANG	AFANEBANG	MIKOMISENG
61	EUGENIA ASANGONO NGUEMA	56	AYANTANGAN	AYANTANGAN	MIKOMISENG
62	PAULA NCHAMA EDU	45	MEBAN ETETEN	MEBAN ETETEN	MIKOMISENG
63	CRISTINA MOKUY NSUE	46	CASCO URBANO	CASCO URBANO	EBIBEYIN
64	ANA MARIA NTONGONO NVONO	43	MBASEE NZOMO	MBASEE NZOMO	EBIBEYIN
65	IDILTRUDIS OBONO ONDO	32	MESAA CONCENTR.	MESAA CONCENTR.	EBIBEYIN
66	NATALIA NKARA OBAMA	60	ESON ESENG	ESON ESENG	EBIBEYIN
67	AGRIPINA OBANGO MENANA	30	MINANG ESANDON	MINANG ESANDON	EBIBEYIN
68	GERTRUDIS NSUGA OBAMA	35	NDUMU ESENG	NDUMU ESENG	EBIBEYIN
69	EMILIANA MOKUY EDU	33	TOM ESENG	TOM ESENG	EBIBEYIN
70	MARIA LUISA ANGUE MITUY	21	BIDJABIDJAN	BIDJABIDJAN	EBIBEYIN
71	BENITA MBANG OBAMA	35	WORAYOP CTDO	WORAYOP CTDO	EBIBEYIN

Annex 2: Treatment protocol

1. Women with obstetric fistula from urinary aparatus and vaginal rectus will be assisted by an ONLY WAY CARE which will be created in September 2005.

2. During the assistance, will participate: an urologist, a surgeon, a gynecologist, a radiologist and High Level Nurses (HLN) followed by health auxiliars. If necessary, the assistance of a psycologist will be strongly recommended.

3. For the reception, a consultation unit will be created in the regional hospitals of Bata and Malabo, conducted by the urologist and gyneco-obstetra, at a weekly level.

4. In these consultation, women will participe under previous announcement or espontaneously on the basis of the listed beneficiaries from the survey.

5. All activities, either for reception in consultation, hospitalary solution (admission-operation), or postchirurgical follow-up, will have statistical control (forms attached).

6. A unit of 5 or 10 bed will be created at maternities of Bata and Malabo, specifically to solve obstetrical fistulas, where will be hospitalized, besides pre and post operation cares.

7. A High Level Nurse (HLN) will be available each morning who will assist the unit during the functioning.

8. Other paramedical personnel (HLN and auxiliars) of the maternity will be trained on handling process of these cases of fistula. Will be responsible of the training: Maternity Director, doctors from the cuban cooperation team, maternity supervisor, etc.

9. Necessary radiological tests contrasted will be freely conducted, in necessary, ecographic test could also be conducted.

10. For the confirmation diagnosis of the cases of fistula, it is necessary to dispose for each patient: syringes of 20 cc, steril gloves, vesical sonda, methilenial blue, vaginal speculum as well as serum for dilution of colorants.

11. Previous free pre-operation tests (Hb, gg, RH factor, Serology and HIV check) will be necessary.

12. Hospitalization fees (hospitalisation costs) will be calculated at a minimum stage of 15 days at a maximum stage of 21 days.

13. The estimation for the costs of women with obstetric fistula (free of charge) will be approximately 115.000 F CFA per woman.

14. Clinic statemet for patients at 100% of the cases operated and/or assisted in hospitals for the control and final information.

15. Final information on cases will be available when operations finally conducted and results known.

16. After protocol conducted, a meeting for discussion of the protocol with all the factors of intervention and execution of the project will be held.

Annex 3: Work Plan Propossal (September 2005 to December 2006)

OBJECTIVES, PRODUCTS AND PERIOD INDICATORS	ACTIVITIES	PERIOD (Smstrs)			PARTNERS	SOURCE OF FUNDING (FCFA)			
		S1	S2	S3		GOVT	UNFPA	EC	TOTAL
Product 1: Operative capacities of health structures reinforced for prevention and adequate handling of obstetric fistula.									
Three (3) maternities rehabilitated in Malabo, Mongomo, Ebibeyin and Annobón.	Rehabilitation of 3 maternities (1 regional and 2 provincials) in Malabo, Mongomo Annobón and Ebibeyin	x	x	x	MINISABS/ UNFPA/EC	25.000.000	0	0	25.000.000
Seven (7) maternities well equiped with essential drugs.	Equipment of seven (7) maternities: 2 regionals and 5 provincials, with essential drugs.		x		UNFPA/CE	0	10.000.000	7.000.000	17.000.000
324 agents trained in ESOC and EMOC within the 18 country districts (including village councils (VC).	Training/retraining of 54 nurses, delivery auxiliar personnel and 270 traditional midwives to reinforce ESOC and EMOC within 18 districts in 5 days duration.	x	x	x	MINISABS/ UNFPA/CE	22.000.000	16.500.000	8.000.000	46.500.000
Product 2: Reinforced information to the population on Essential Obsteric Care (ESOC) and Emmergency Obstetric Care (EMOC) to reduce obstetric fistula cases.									
Developed advocacy actions for the economical insertion of women with obstetric fistula.	Development of advocacy actions for the reparation and economical reinsertion of women with obstetric fistula.	x	x	x	MINISABS/ UNFPA/CE	2.500.000	0	0	2.500.000
Health personnel sensitized on obstetric fistula by sex.	Four (4) sensitisation sessions of 2 days duration to health personnel (doctors, nurses, midwives, delivery auxiliar personnel, traditional midwives, etc.) on obstetric fistula.	x	x	x	MINISABS/ UNFPA/CE	5.000.000	500.000	5.000.000	10.500.000
Educative messages developped on Essential Obstetric Care (ESOC) and Emmergency Obstetric Care (EMOC), at community level.	Development of educative messages regarding Essential Obstetric Care (ESOC) and Emmergency Obstetric Care (EMOC) at community level.	x	x	x	MINISABS/ UNFPA/CE	4.000.000	6.000.000	4.000.000	14.000.000
Product 3: Reparation of conducted obstetric fistula cases with a post operation follow-up									
Two (2) operative units for the reparation of obstetric fistula cases.	Establishment of two (2) regional hospitals in Malabo and Bata to repair obstetric fistula cases.	x	x		MINISABS	0	0	0	0
Two (2) stablished and operational specialists team for obstetric fistula repair.	Stablishment of a two (2) operational team of specialists on obstetric fistula repair constituted of 1 urologist, 1 surgoen, 1 gynecologist, 1 radiologist, 1 psicologist, 2 nurses and 3 health auxiliars.		x		MINISABS	850.000	0	0	850.000
SUB-TOTAL PAGE (1)						59.350.000	33.000.000	24.000.000	116.350.000

OBJECTIVES, PRODUCTS AND PERIOD INDICATORS	ACTIVITIES	PERIOD (Smstrs)			PARTNERS	SOURCE OF FUNDING (FCFA)			
		S1	S2	S3		GOVT	UNFPA	EC	TOTAL
Product 3 (continuation): Reparation of conducted obstetric fistula cases with a post operation follow-up.									
Necessary available material for diagnosys and obstetric fistula repair.	Revision and provision of necessary material for the diagnosys and obstetric fistula repair.	x	x	x	MINISABS/ UNFPA/CE	0	5.700.000	5.000.000	10.700.000
Data recording books available and utilized.	Adquisition of data recording books for consultations, operations, hospitalisations and clinic records.	x	x	x	MINISABS/	0	700.000	0	700.000
Vehicles and logistic support available to retrieve, transportate and mobilize women with obstetric fistula.	Logistic support and vehicles to retrieve, mobilize and transportation of women with obstetric fistula.	x	x	x	UNFPA/CE	1.500.000	2.500.000	0	4.000.000
Confirmed diagnosys of obstetric fistula cases in Malabo and Bata.	Confirmation of diagnosys of obstetric fistula cases identified during the survey in Malabo and Bata hospitals.	x	x	x	MINISABS/	1.600.000	0	0	1.600.000
Fungible, material and essential drugs available.	Contribution of acquisition of fungibles, material and essential drugs.	x	x	x	UNFPA/CE	0	5.700.000	4.000.000	9.700.000
Available chirurgical repair programmes in Malabo and Bata.	Execution of chirurgical repair programmes in Malabo and Bata hospitals, assisted by Nigeria and Addis Abbeba teams.	x	x	x	MINISABS/	0	5.500.000	2.000.000	7.500.000
Available motivation programme on chirurgical obstetric fistula repair in Malabo and Bata.	Economical motivation support programme to obstetric fistula repair team in Malabo and Bata hospitals.	x	x	x	MINISABS/ UNFPA/CE	3.500.000	2.500.000	0	6.000.000
Product 4: Women effective socio – economical reinsertion after obstetric fistula operations.									
Executed follow up activities.	Women post operation follow up in conseiling and medicochirurgical consultations.	x	x	x	MINISABS/ UNFPA/CE	700.000	0	0	700.000
Operative in-come generation activities.	Assistance and promotion of women income generation activities after obstetric fistula operations.	x	x	x	MINISABS/ UNFPA/CE	10.000.000	3.000.000	3.000.000	16.000.000
Psycosocial accompaniement of women after obstetric fistula operations.	Familiar and community psycosocial accompainement of women after obstetric fistula operations.	x	x	x	MINISABS/ UNFPA/CE	0	1.200.000	1.200.000	2.400.000
SUB-TOTAL PAGE (2)						17.300.000	26.800.000	15.200.000	59.300.000
GRAND TOTAL (Pages 1+2)						**76.650.000**	**59.800.000**	**39.200.000**	**175.650.000**

Annex 4: Data collection tools

REPUBLICA DE GUINEA ECUATORIAL
MINISTERIO DE SANIDAD Y BIENESTAR SOCIAL

FONDO DE POBLACIÓN
DE LAS NACIONES UNIDAS

**NATIONAL PROGRAMME
FOR REPRODUCTIVE HEALTH**

DATA COLLECTION TOOLS FOR OBSTETRIC FISTULA IN EQUATORIAL GUINEA

QUESTIONNAIRE 1

***(Addressed to hospital directors,
doctors, surgeons, ginecologists, urologists
and hospital service responsibles).***

<u>QUESTIONNAIRE 1: (Status of health structures)</u>

(Addressed to hospital directors, doctors, surgeons, ginecologists, sociologists and responsible of hospital services.).

QUESTIONNAIRE / CARTHOGRAPHIC EXERCICE ON OBSTETRIC FÍSTULA (Needs evaluation)

Questions:

1. Make a brief description of actual status of this problem at country level, on information, data prevalence, public health interest, professional associations (midwives, obstetrics), NGOs, RH donors, etc...
   ....
   Note if obstetric fistula is considered as an important issue and identificate type of available ressources to handle this issue:
   Human ressources ....
   Material ressources ....
   Financial ressources ....

NB:
Pollster, having a delicate issue and still unknown in our area, this initial sounding will require, of course, a serie of conversations with different local health agents to find those who are well informed and accepts discussing fistula problems. Do not forget that most of fistula cases are a consequence of a bad executed deliveries and, ***<u>victims are</u>*** *young poor women, isolated/excluded…*

2. Are there any health centers suitable for treatment and re-education/rehabilitation of women with fistula (generally urology services, others)? Yes ☐ No ☐

   If yes, evaluate the following elements for each center:
   - Autonome center, hospital pavilion, private and public (Map)..
   - Number of yearly fistula repair (porcentage considered "succesful" (definite "succesful"), complications, sequels..
   - Geographic provenance of patients...
   - Number of urologists specialists ....general surgeons...
   - obstetrics ....able or anxious to repair fistulas.
   - Number of trained nurses participating in fistula operations...
   - Number of trained persons on post operational cares..
   - Supervision of clinic service personnel by local supervisors (as well as regional specialists).......
   - Treatment possibilities ....
   - and delayed period before treatment (reparation)...
   - Operation costs (including admitance, drugs)..
   - Improvement possibilities, service expansion (please note wether the center can be positioned to become a national/regional training center)...
     ....

3. What are the source of funding of these health centers?..
   ....
   ....
   If there are admittance fees, treatments, make a sounding to consider if these fees are:
   - Reasonable: Yes ☐ No ☐
   - Accesible to poor people: Yes ☐ No ☐
   - Or if there are being received as disuassives: Yes ☐ No ☐ for potential clients

4. For each center, please evaluate the following points:

- Infrastructure: availability of a surgeon unit for fistula repair: Yes ☐ No ☐
- Equipment, fungible material (sounds, etc.): Yes ☐ No ☐
- Medical and chirurgical fungible material..…………..
- Information needs for surgeons, nurses, midwives, health agents: Yes ☐ No ☐
- Administrative questions (salaries, maintenance costs, fungible materials, general expenses, control of the infection)...…………………....
- The level of available Essential Obstetric Cares (ESOC) and Emmergency Obstetric Cares (EMOC) in:Regions………..............…...........Provinces……………..........……..Districts.……………................
- Number of deliveries during 2004................and monthly delivery rate in 2004.……...........…………..
- Number of instrumental childbirths (spatula or forceps)....................... and the proportion of 2004 number of deliveries…………………………...………………………….

5. What Information, Education and Communication (IEC) activities are implemented to help women be well informed on the services that can contribute to treatement and social reinsertion after treatement?......................………………………………………………………………………………….
....
(Please make a sounding on education and information necessities and available services for the prevention in the community) ………………………………………………………………….
....
....
6. If a new fistula reparation center is required, please make a breaf description of arguments, advantages and evaluate corresponding construction costs as well as necessary equipment..……………………………...
....
7. Which are the main advocacy activities toward responsibles of health sector, chirurgical agent service providers, professional associations and publics (civil society: associations, medias, elected?…..……………………………………...
....
8. Can you recommend 2 to 4 names of national specialists to be trained on medico-chirurgical, and sociocultural bases on obstetric fistula handling? Yes ☐ No ☐
   If yes, please mention these specialists:
   a...
   b...
   c...
   d...

   (***NB: Pollster, take soundings wether they are specialiced and ready to intervene in national/regional plan)***
   ....
   ....
   ....

Pollster's signature, **Date:....………..........................…………...**

Supervisor's signature, **Date:...........………......………………......................**

REPUBLICA DE GUINEA ECUATORIAL
MINISTERIO DE SANIDAD Y BIENESTAR SOCIAL

FONDO DE POBLACIÓN
DE LAS NACIONES UNIDAS

NATIONAL PROGRAMME
FOR REPRODUCTIVE HEALTH

DATA COLLECTION TOOLS FOR OBSTETRIC FISTULA IN EQUATORIAL GUINEA

QUESTIONNAIRE 2

(Addressed to delivery assistance personnel (doctors and other key community personnel)

QUESTIONNAIRE 2 :

(Addressed to delivery assistance personnel (doctors, gynecologists, surgeons, matronas, midwives, nurses, delivery auxiliars, traditional midwives and other key community personnel)

Province: ……...……..........
District: ....……......
Location: ....……..
Civil status: ....……..
Names:..Family names: ....……...
Age:…..............years Addres:………..
....……..

PROFESSIONAL EXPERIENCE (Number of years of experience): ………………………………….

STATUS:

Generalist-doctor ▢ Gyneco-obstetric doctor ▢ Surgeon ▢ Matron ▢ Midwive ▢ Nurse ▢
Delivery auxiliar ▢ Traditional midwive ▢ Health community agent ▢ Others (indicate) ▢ ………

PLACE OF EXERCICE:

Home ▢ Health post ▢ Health center ▢ Hospital:

Regional ▢
Provintial ▢
District ▢

ABOUT OBSTETRIC FISTULA:

1. Do you know what is an obstetric fistula? Yes ▢ No ▢
   If yes, what are the main symptom of obstetric fistula?………………….....................................
   ....
   ....
   and the causes of obstetric fistula?…...
   ....

2. What do you know about handling and treatement of obstetric fistula?....................................
   ....

3. Do you know people with obstetric fistula in your area? Yes ▢ No ▢
   If yes, please give their names and addresses (continue with questionnaire 3)
   ....
   ....

Pollster’s signature, Date:....…………...............................………….....

Supervisor’s signature, Date:.................………….............…………......

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QUESTIONNAIRE 3

(Addressed to women with obstetric fistula)

QUESTIONNAIRE 3: (Addressed to women with fistula)

Province: ……………...
District:…………...
Location:…………..
Civil status:..…………..
Name:..…......................................Family names:..……......................................Age:........….years
Profession: ....……………………..
Etnic group:......................... Place of residence:...…………
Number of deliveries:............................... Number of pregnancies: ....…………

Instructions level: Illiterate ▢ Primary ▢ Secondary ▢ Superior ▢ Other ▢
Source of incomes: Housband ▢ Family ▢ Same woman ▢ Mendicity ▢ Other (indicate) ▢
....…………..

ABOUT FISTULA

1. Age of woman at first delivery:..……...…………...............................

2. Age of woman during fistula apparition:………………….............................…………............…

3. Fistula ancianity (years, months, weeks):………..……………

4. With how many deliveries did you get your fistula?:...………….

5. Was it a planned/wanted pregnancy? Yes ▢ No ▢

6. How long was the delivery? (hours)....................……….......................................…………

7. Was it an assisted delivery?: Yes ▢ No ▢

8. Place of delivery:..…………

9. How did you get to the place of delivery?...…………

10. Was it a transfert?: Yes ▢ No ▢
    If yes, with which means?...........……………...…………

11. At what distance?: …..………….

12. Nature of delivery:

    Normal
    - Spontaneous
    - Manual handling
    - Instrumental handling

    Caesarean
    Alive child ▢
    Dead child ▢

13. Distance between the place of residence and the nearest health structure:……………………....

14. Distance from place of residence to the nearest chirurgical unit:………......................................

15. Patients possible pre/post operatory accomodation (family level): Yes ▢ No ▢

16. How do you live with your fistula?..
....
....
....

Possible comments of the pollster:
....
....

17. What do you think as the cause of your fistula? ....

18. Have you ever seek for a medical or traditional treatement? Yes ☐ No ☐
If yes, which? ....
And where? ....

19. Have you ever be operated? Yes ☐ No ☐
If yes: where? ....
....
and how many times? ....

20. What was the result? Good ☐ Bad ☐
If bad, why? ....
....
....

21. What is your family's reaction face to this situation?:

Housband:	rejection ☐	assistance ☐	indifference ☐
Family:	rejection ☐	assistance ☐	indifference ☐
Environmet:	rejection ☐	assistance ☐	indifference ☐

22. Do you know something about fístula? Yes ☐ No ☐
....
....
....

23. Do you know that it can be treated? Yes ☐ No ☐
....
....

24. In order to be well, do you accept to be operated? Yes ☐ No ☐

If not, why? ....
....
....

25. What is your actual desire? ....
....
....

Pollster's signature, Date:...

Supervisor's signature, Date:...

Annex 5:

List of national research team

NO	NAMES AND FAMILY NAMES	CATEGORY	DEPARTMENT AND LOCATION
1	Dª Gertrudis Nzang Ndong	National Coordinator for RH	Ministry of Health, Malabo
2	Dr. Antonio Maria Oyono	Chief, Epidemiology Unit	Ministry of Health, Malabo
3	D. Rafael Ondo Esono	Director Health center M. Bisila	Ministry of Health, Malabo
4	Dª Nieves Nzang Ndong	Regional Coordinator for RH	Health Regional Unit (Bata)
5	D. Eugenio Edu Obono	Nat. Director Health Inf. System	Ministry of Health, Malabo
6	Dª Asunción Ntzemo	Midwife	Regional Hospital, Malabo
7	Dª Mariana Toichoa Ada	IEC/Advocacy Specialist	Ministry of Information (Bata)
8	Dª Maria Elena Ntutumu	RH project Secretary	Health Regional Unit (Bata)
9	D. Justo Ona Sima	RH Adm. and Finance Assistant	UNFPA/Minist. Health, Malabo
10	Dr. Oumar Balde	RH International Expert	UNFPA/Minist. Health, Malabo
11	D. Jaime Nsue Esono	Programme Manager	UNFPA Malabo
12	Dra. Teresita Alene	Chief, Maternity Unit	Bata Regional Hospital
13	Profesor Francisco Perera	Ginec./Professor. Medicin Faculty	Bata Regional Hospital

NARRATIVE TESTIMONY FOR WOMEN WITH TRAUMATIC AND OBSTETRIC FISTULA*.*

1. WOMAN WITH FÍSTULA, ASSISTED BY HER FAMILY AND THE ENVIRONMENT.

I am a 22 years old, married woman and live in Ela Nguema military campus.

I had this sickness in my first delivery, in Ncomekok village council, in Anisock district, a 23 km far village from the district hospital. They were no trained people to asist me during the delivery, so, I had three days delivery. The head of the fœtus were out during two days and they were no available vehicle for my urgent evacuation to the hospital o health center. Women of the village helped to remove the fœtus, it was already dead.

From that moment, I started to note constant flows in my vagina and so I went to the Regional Hospital of Bata. I met a chinese doctor who told me that I could only be well if I am urgently evacuated to Cameroon. After one year, my husband financed my trip to Cameroon accompanied by his sister. This village is called Enong Ngaha. We got there and had my first operation.

After operation, I could not note any sign of difference. I still suffring from the same sickness, inspite of the operation; there were no improvement, my vagina continued to flow and that I am still having the same problem.

My husband and family gives me all the necessary help, as well as all neighbors of the village. They make me happy.

2. WOMAN WITH FISTULA AT AN EARLY AGE

I am a 26 years old, married woman, and live in Campo Yaunde quarter of Malabo.

I have had two deliveries. This sickness took place in the first delivery, when I was 15 years old. That occured in my house, too near from the hospital.

When I started to fill delivery pains, inspite of the near distance of my house to the hospital, I had five days with delivery pains, nobody took me to the hospital. These pains were so long and due to my bad situation I was finaly transfered to the hospital where I found a midwife. I received manual assistance from her as a result, the fœtus was dead.

After delivery, and due to its complication, I was hospitalized for almost three days and then went home the following day. After three weeks, I started to fill constants flows in my vagin and the odor was very bad. From that time, I could not control my urin, so I was very worried and decided to go back to the hospital.

The doctor gave me some drugs, but could not solve the problem, then revealed that I could be operated once again.

My husband financed operation costs, it was conducted in Mongomo provincial hospital, nevertheless, the operation was not succesfull, as a result, I was recommended a second operation, also in Mongomo, and in same conditions: without any success, so I decided to go to Malabo, to find a solution, situation which persisted for 10 years.

3. WOMAN WITH FISTULA WITHOUT DELIVERY (TRAUMATIC)

I live in Bareso village in northern Bioko island, am 25 years old and am married.

I have never bear a child in my life, but, I had this sickness as a consequence of a sexual brutal violation that I experienced when I was 13 years old. This was a criminal and unforgetful event that I will carry over me for the rest of my life.

Up on a time, I got married. At the age of 19 years old I felt constant flows in my vagin, urinating without control, beside a bad and constant odor from this urine. This situation persisted for more than 6 years, so that I could not be pregnant, and that makes me think about the sexual violation that I had when I was 13 years old.

Inspite of that, I am strongly benefiting from my husband's continuing help, but as a result of this great preocupation, both my husband and I, decided to go to the hospital in order to see the doctor. After the consultation, a drug prescription was given to me in order to find so many drugs, even I did not have any positive result.

I continue to have the sickness and seek for help.

4. REJECTED WOMAN WITH OBSTETRIC FISTULA.

I live in SEMU quarter (Malabo), in the north of Bioko. I am 40 years old, a married woman, even, abandoned by my husband, due to my sickness.

At 16 years old, I had my first and only pregnancy, I delivered a child after 9 months pregnancy, during delivery pains, my family took me to the hospital using a wheelbarow. Delivery operations were so long as they were for almost 5 days. This was a very wanted pregnancy, even my child deceased. After delivery, I was hospitalized for 2 days the third day I was released and went home.

After four months delivery, I started to fill constant flows in my vagina with a bad odor, as well as uncontroled urines. I considered that this could stop immediately, but it continued without stopping, so I decided to go to the hospital in order to see the doctor, where I had my delivery.

The doctor gave me a medical prescription, which could not help me. After the medication, I went again to the doctor and in that moment, he suggested a second operation. I was operated again in Malabo hospital and had the same problem, viewing this situation, I decided to go to Cameroon to have the second, but unsuccesful operation; I could not be well, after that, I was recommended for a third operation, due to the lack of financial ressources, the operation could not be conducted as I am trying to face my economical problems without any help. I have this sickness for more than 8 years.

5. WOMAN WITH FÍSTULA, AFTER MORE THAN 100 HOURS DELIVERY.

I live in Avang Esatop, a village of Nsocknsomo of Kie Ntem province. I am 25 years old, a married and jobless woman. I have had 6 pregnancies and 6 deliveries.

When I was 15 yeas old, I had my first delivery in which I had pains from my house. It was a delivery pains. After 5 days I delivered a child and had 5 delivery painful days. I was assisted by a village woman she was not traditional midwife, inspite of the 15 km distance to the hospital, but, my family did not take me anywhere, I am sure that my child deceased due to this situaion, even it was a wanted pregnancy.

After 2 months delivery, my vagin started to receive constant flows and bad odor. I noticed that I was urinating uncontroledly, and in view of that, I went to the hospital of Bata were I was operated. But I could not be well. So, I decided to go to Cameroon to have a second operation. I did not have any positive solution.

I have this sickness for 10 years, my housband help me a lot that I dont care of all this situation.

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