

Ministry Of Health and UNFPA

**Needs Assessment of Obstetric
Fistula in Malawi**

BY

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1.0 Introduction

Malawi has been addressing maternal health since 1987. And with the inauguration of safe Motherhood Initiative in Nairobi in 1987 specific programmes to reduce maternal mortality and improve maternal health were established.

With UNFPA support, a multi agency Safe Motherhood Task Force was established in late 1992 to steer the development of a more comprehensive National Safe Motherhood programme for Malawi whose secretariat was established at the National Family Welfare Council of Malawi. In 1994, a Safe Motherhood Needs Assessment was done and based on its recommendations a 5-year safe motherhood strategic plan was developed in 1995 and its aim was to:

- Raise awareness and generate political, government and donor commitment to safe motherhood
- Reduce the number of adolescent and/or unwanted pregnancies
- Improve the quality of care
- Reduce the delay in obtaining essential obstetric care

A number of development partners have been supporting safe motherhood activities in Malawi. DFID supported the Safe Motherhood Initiative activities in 12 districts in southern region while UNICEF, UNFPA and WHO have been supporting some districts in central and northern regions. However, despite all these efforts maternal mortality ratio has increased from 620 in 1992 to 1120 in 2000 (DHS 2000). This mortality rate is higher than in most countries in the Southern Africa Region.

Globally, an estimated 600,000 women die every year due to pregnancy related complications, 99% of them in developing countries and for every maternal death, 30% or more women suffer disabling and humiliating injuries including obstetric fistula. While fistula is a global problem, it is particularly common in Africa, which is a low resource setting. Unrelieved obstructed labour, which has social, nutritional and health care dimensions, is the main cause of obstetric fistula. Studies in Africa have shown that 58 to 80% of women with obstetric fistulae are under the age of 20 with the youngest patient only 12 years of age. The vulnerability of young girls to the development of obstetric fistula is closely related to their physical immaturity and the less developed pelvis. There is need to raise the age at marriage, avoid teenage pregnancy and provision of emergency obstetric care to teenagers in order to prevent development of obstetric fistula.

Obstetric fistula is one of the most serious and disabling complications of childbirth, which has virtually been eliminated in developed countries but is still prevalent in the developing world including Malawi. Obstetric Fistula usually follows prolonged obstructed labour commonly arising from cephalo-pelvic

disproportion (CPD) and poor obstetric care. It specifically occurs due to necrosis of the anterior and sometimes posterior vaginal walls, bladder, urethra and rectum, which has been compressed between the foetal head and the symphysis pubis. Incontinence occurs when the dead tissue slough off, usually between the 4th and the 14th day after delivery. The size of the fistula may vary from very small (with only occasional leaking when the bladder is full to very extensive (with total loss of bladder floor, urethra and cervix). The very young and the poor are disproportionately affected.

Obstetric fistula is preventable and treatable. Most women are either unaware that treatment is available or cannot afford it. Some women will try traditional treatment at home and when they do not see an improvement then they visit a health facility after months and months of suffering. In some cases neurological damage to the legs caused by prolonged labour result in “foot drop”, a condition that may completely impair one’s ability to walk.

15% of pregnancies results in obstetric complications that require emergency obstetric care. Fistula occur as a result of the three delays in obtaining appropriate Emergency Obstetric Care: delay in deciding to seek medical attention, delay in reaching the health facility and delay in receiving emergency obstetric care at the health facility.

Most pregnancy related deaths occur around the time of delivery or during postpartum period. In Malawi 91% of pregnant women attend antenatal clinic at least once during pregnancy and the median number of antenatal care visits was 3.4 in the 2000 DHS. 56% of women deliver in a health institution, a figure relatively low but higher than the other countries in the SADC region. For example, in Kenya only 44% deliver in health institutions (KDHS 1998). Zambia’s 47% of deliveries are attended by a skilled health worker and approximately 44% of deliveries in Mozambique happen within institutions. It should however be noted that maternal deaths in these other countries are lower than in Malawi.

One of the contributing factors to high maternal deaths is poor quality of care. In November 2003 Malawi conducted a study to assess obstetric quality of care in district hospitals and health centres. The study among other things revealed that much as 56% of deliveries are conducted at a health facility, some of the personnel performing deliveries are not trained to provide this service. At district hospitals generally all cadres of nurse midwives attended deliveries more frequently than the rest of the staff. It was noted however that support staff such as hospital attendant and patient attendants had also attended to 11% of deliveries three months prior to the study. At health centre level enrolled nurse/midwives attended 28% of the deliveries. Surprisingly the highest frequency of all cadres that attended a delivery is the hospital attendant (cleaner) who attended to 37% of all the deliveries. The Health Surveillance Assistant stands out as the third category that attended to deliveries more frequently at (22%).

Poor access and referral systems due to long distances are also some of the reasons why 44% of the women deliver at home with TBAs or relatives. Obstetric labour is a common outcome of home deliveries. It should be noted that some of the women who developed VVF in Malawi was not due to delay in seeking care but due to delays in being attended to in the health facility.

1.1 Background

UNFPA and Engender Health conducted a needs assessment study covering nine countries in sub-Saharan Africa including Malawi in the year 2002. The obstetric fistula needs assessment findings report was launched on 18th June 2003. The report noted that obstetric fistula is a pregnancy related disability affecting an estimated 50,000 to 100,000 women each year and also that the estimated two million women living with obstetric fistula are too few since they are based on women seeking treatment in medical facilities. The report noted that factors that precipitate obstetric fistula are cross cutting and include: malnutrition and possibility of repeated infections, poor access to emergency obstetric care, preference to deliver at home with TBAs and relatives and poorly managed Caesarean sections at health facilities.

This problem is aggravated by poverty, women's poor status in society and lack of education, preventing them from getting services to avert or cure the condition. In spite of these, in the countries studied it was observed that obstetric fistula is not acknowledged as a critical problem requiring immediate attention. There are inadequate facilities and a poor referral system, skilled staff to handle fistula are few, awareness of the problem at community level is low and cultural practices such as early marriages are very common. Malawi is one of the countries where the study was undertaken and it covered Queen Elizabeth Central, Zomba Central, Mulanje District, Machinga District, Mwaiwathu and Nkhoma hospitals.

UNFPA Malawi office and Engender Health conducted dissemination meetings with staff from the hospitals where the study was done. In February 2004 a two-day stakeholders meeting with participants from Ministry of Health, CHAM training institutions, professional bodies, donors and NGOs was convened by MOH with financial and technical support from Engender Health and UNFPA. The outcome of the stakeholders meeting was the establishment of the obstetric fistula task force comprising of individuals interested and committed to address issues of fistula and these were from MOH, UNFPA Malawi, CHAM, medical college and Nurses and Midwives Council. The task force members observed that the study conducted by UNFPA and engender health did not come up with adequate data on obstetric fistula hence the need to collect more information on the six hospitals currently providing fistula repair services in the country.

This study is meant to compliment the UNFPA/EngenderHealth study. It does not cover issues of community awareness of obstetric fistula, community beliefs,

prevention of obstetric fistula as well as provision of obstetric care. The Emergency Task Force on Safe Motherhood adequately covers prevention and obstetric care. This study is then focussing on medical treatment of obstetric fistula.

1.2 Study objectives

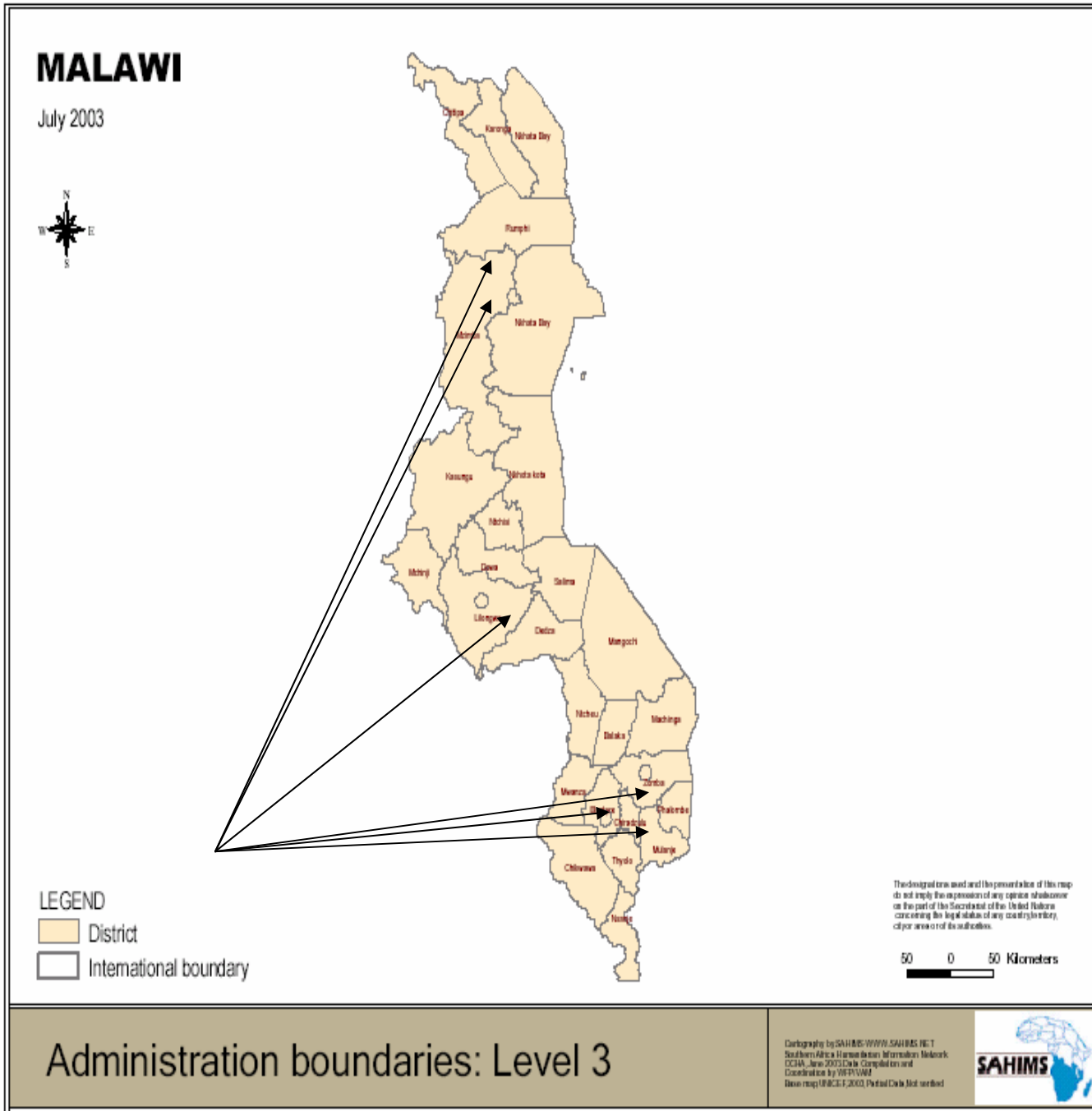
The objectives of the study were to

- a) Assess availability and utilisation of fistula repair services.
- b) Establish the waiting period between the time of booking and repair.
- c) Identify areas where most of the fistula patients are coming from
- d) Identify the training needs.
- e) Assess availability of equipment and supplies
- f) Make suggestions and recommendations for the way forward.

1.3 Methodology

Data collection for this study was conducted between 25th September and 1st October 2004 covering six hospitals of Malawi namely: Queen Elizabeth and Zomba Central Hospitals and Mulanje Mission Hospital in the southern region, Nkhoma Mission Hospital in the central region and Mzuzu Central Hospital and Ekwendeni Mission hospital in the northern region. A data collection tool was used and it was designed to collect both qualitative and quantitative data. Data was collected from the gynaecologists, ward in-charges and patients admitted with fistulae through interviews. Records of patients admitted in the hospital with fistula were also reviewed. Below is figure 1 highlighting sites visited during the study.

Figure 1 Map of Malawi highlighting sites visited



2. Findings

2.1 Availability

Fistula repair services are available in the six health facilities visited. However, the services are more concentrated in southern region. For example the obstetrician from Zomba central hospital provides services at the central hospital and also conducts outreach services to Mangochi, Machinga and Balaka hospitals. At Queen Elizabeth Central hospital there is an obstetrician who provides the services at the hospital and also provides outreach services to Mulanje and Phalombe hospitals. There is also another surgeon who is providing services to Thyolo, Mwanza and Chikwawa hospitals. It was however noted that the surgeons do not visit Nsanje hospital but the patients from Nsanje are requested to travel to Chikwawa hospital, a distance of over 80 kilometers. Generally the southern region is well covered. The surgeons conduct outreach services monthly. It is only Phalombe hospital that is visited every two months.

Central region has nine districts and services are provided at Nkhoma Mission hospital only. Patients from Lilongwe Central hospital are sent to Nkhoma for repairs. The other eight districts are not served. Services in the northern region are available at Mzuzu central hospital and Ekwendeni mission hospital. The surgeons at these hospitals are not providing outreach services hence patients from the other five districts have problems in accessing the services.

The visiting team noted that although the services are available and some institutions have been providing services for over 40 years as can be seen on Table 1, pre- and post-operative guidelines/protocols are not available in most of the institutions. Nkhoma mission hospital had a copy of a protocol for all surgical cases including VVF repaired using vaginal approach and abdominal approach. However, they are very brief. The team was also informed that guidelines are available at Ekwendeni Mission hospital but it was not possible to access a copy of the guidelines. The guidelines are very important especially for the nursing personnel, as some of them are not very sure on how to manage a fistula patient post operatively. The guidelines will also be useful when the patients are being discharged. The visiting team found that after successful repair the patients are given different types of information. Some hospitals advise the patient to abstain for one month, others six weeks, 3 months; 6 months and one hospital advises the patients to abstain for one year. Some healthy facilities advise on family planning while others do not. Others give information on nutrition and pelvic floor exercise while others do not. It was noted however that all health facilities advised the patients on future pregnancies in terms of early antenatal care and delivery through caesarean section

2.2 Utilisation of fistula repair services

Data was collected for the year 2003 and fistula repair ranged from 2 cases in Ekwendeni to 55 patients at Queen Elizabeth Central hospital, as can be seen from table 1 below. The team was not able to get information from Nkhoma Mission hospital but from previous data it shows that the magnitude of the problem is increasing. For example the numbers have been increasing from 14 in 1997 to 45 patients in 2001. It should be noted that more patients reported with fistula but some were not repaired due to congestion in the hospital. For example Queen Elizabeth reported that they lost 10% of their patients who never came back probably due to lack of transport.

Table 1: AVAILABILITY AND UTILISATION OF SERVICES

	Queens	Zomba	Mulanje	Nkhoma	Mzuzu C.H.	Ekwendeni
Availability of services	✓	✓	✓	✓	✓	✓
VVF repairs in 2003	50	35	10	No figure	40	2
RVF repairs in 2003	5	2	Nil	No figure	4	0
# of patients found during assessment	14	6	1	4	0	0
# of years of service provision	43 years	5 years	11 years	9 years	4 years	2.5 years

From table 1 above, it can be seen that 148 patients were repaired during the year 2003 and 37% were repaired at Queen Elizabeth Central Hospital. Note that the figures presented do not include patients repaired at Nkhoma mission hospital. Although data for the year 2004 was not collected it seems the problem is getting bigger and bigger. For example Mulanje Mission Hospital had 10 repairs in 2003, the hospital has already repaired more patients than last year (14).

BOX1

The surgeon is really helping these patients. They come here dripping urine everywhere and most of them go home dry. He is really successful in his repairs. The success rate is over 80% and we are so sad that he is now leaving Malawi. I do not know what will happen to these patients

Sister In-Charge- Zomba Central Hospital

Below is a picture of a happy and satisfied patient who had a fistula repaired, she later became pregnant and was delivered through a c/section at Nkhoma Mission hospital. (Picture courtesy of Nkhoma hospital)



As already stated above outreach services are provided in Southern region only. It was difficult to establish the number of patients that are repaired during outreach service, as records are not kept by the surgeons but by individual hospitals. It was however learnt that 3 patients were repaired in Chikwawa and 4 in Mwanza during the year 2003.

In all the hospitals visited, the main cause of fistula was obstructed labour accounting for about 90% of the cases followed by surgical accidents and cervical cancers. For example during the time of the survey, 21 patients found in the gynae ward with fistula were interviewed and their records reviewed. It was found that obstructed labour was the cause of fistula in 18 patients (86%), 2 patients due to surgical accident (9.5%), one had haemorrhoids and developed fistula after removal while the other one had bladder stones and also developed fistula after removal of stones and the last patient due to cancer of cervix.

2.2. 1 Cost of the fistula service

This assessment was done in three government and three CHAM hospitals. CHAM hospitals usually charge for services however it was found that fistula patients are exempted. At Mulanje mission the cost of fistula repair is MK3,000 (US\$28) but the institution is using donated funds from a group of churches in the US. Nkhoma mission has a special fund for fistula patients. Ekwendeni mission normally charges for fistula repair but currently the patients are not paying because they have special funds donated by an American doctor who once worked at the hospital. Although patients are not paying for fistula services, there are some hidden costs that the patients have to meet. For example a patient at Queen Elizabeth Central hospital told the interviewers that she was going to abscond from hospital because she had no food. Although the hospital was providing food, the supply was not adequate for her and her elderly grandmother who was her guardian and they had no money to buy extra food.

2.3 Waiting period between the time of booking and repair

It was found that the waiting period varied from less than one month to more than one month as indicated in Table 2 below.

Table 2: WAITING PERIOD

	Less than 1 month	1-3 months	3 – 6 months	More than 6 months
Queens				♣
Zomba	♣			
Mulanje		♣		
Nkhoma	♣			
Mzuzu C.H	♣			
Ekwendeni		♣		

At Zomba central hospital, the waiting time is one week only. The waiting period also depends on whether fistula has occurred in the hospital or the patient has been referred from other hospitals or she has come to the hospital on her own. When a fistula occurs at the hospitals visited, the patient is told to go home and wait for three months with the hope that the fistula will close spontaneously. It was found that most of the patients who came with obstetric fistula were referred from district hospitals; health centres referred a few and very few came on their own. Mostly those who came on their own are from Mozambique.

At Queen Elizabeth hospital, the waiting time is more than six months and the average waiting time is eight months. There is congestion of patients at Queens as well as lack of space in theatre. There is one theatre being shared by seven surgeons and as a result they take turns in the use of the theatre. The surgeon who is currently doing repairs has access to theatre once in two weeks. It was

noted that Queen Elizabeth hospital has seven surgeons, only one is doing fistula repairs, the other surgeon conducts repairs at outreach hospitals while the other five are not doing any fistula repairs. Although the other five surgeons are not trained in fistula repairs, most of them are not interested because it is a difficult procedure and it takes a long time and patience. It was not possible to get the views of the other surgeons from QECH but a surgeon from Mulanje said the following:

BOX2

It is not easy to do fistula repairs; It takes time and patience. I have tried several times but I have not been successful. I cannot see a Malawian doctor standing for three hours to do a fistula repair, not with the amount of money they are getting. If we really want these doctors to be motivated then we need to give them some incentives.

Surgeon – Mulanje Mission Hospital

From the information above, it is only Queen Elizabeth Central hospital, which is not able to cope with the current workload. The hospital needs increased number of staff, a theatre and also there is need to encourage the other gynaecologists to do repairs. The other four hospitals are coping very well and they can repair more patients than they are currently doing if they had adequate equipment and supplies, well-trained staff in theatre and also for post operative care. Nkhoma hospital would require accommodation for the patients. Mulanje Mission hospital cannot take extra patients because the operations are done by the Surgeon from Queen Elizabeth Central Hospital who is already overworked.

Table 3 : Data of Fistula Surgeons

Institution	Name	Cadre	Year Trained	Duration of training	Role	Remarks
Q.ECH	Dr. Rijken	Obstetrician/ Gynaecologist		On the Job	Surgeon	Visited Addis for 2 weeks to gain more experience
	Dr. F. Sungani	Obstetrician/ Gynaecologist	1980s	On the Job	Surgeon	Conducts outreach only
ZCH	Dr. Wiscert	Obstetrician/ Gynaecologist	Early 90s	On the Job	Surgeon	Visited Addis for 2 weeks to gain more experience
	Mr. Gondwe	Clinical Officer	April 03	On the Job had 3 days training	Surgeon	Conducts minor repairs only
Nkhoma	Dr. R.Ter Haar	Medical Officer	1989	On the Job	Surgeon	Conducts major repairs
	Dr. Linden	Medical Officer	2004	On the Job	Surgeon	Minor repairs only
Mzuzu C.H.	Dr. Daza	Medical Doctor		On the Job	Surgeon	Conducts major repairs
	Dr. Jeke	Medical Doctor		On the Job	Surgeon	Conducts major repairs
	Mr. Gondwe	Clinical Superintendent			Surgeon	Conducts major repairs
	Mr. Matapila	Senior Clinical Officer	2002- on the Job	2 weeks at Nkhoma	Surgeon	Conducts major repairs
	Mrs. Phiri	Clinical Officer	2004	On the Job	Surgeon	Conducts major repairs
Ekwendeni	Mr. A. Nyirongo	Chief Clinical Officer	2002	6 weeks in Addis	Surgeon	Conducts major repairs

2.4 Areas where most of the patients come from

During interviews with the service providers it was said that most of the patients come from boarder districts such as Chikwawa, Nsanje, Mulanje, Phalombe, Thyolo, Mwanza, Mangochi and Dedza districts. Balaka and Nkhotakota districts are also referring a lot of patients. It was also implied that most of these patients come from Mozambique and not Malawi. However, this is not entirely the case as out of the 21 patients found in the three hospitals in the southern region during the needs assessment, only one was from Mozambique. There is need to find out why some of the districts have many fistula patients. For example, Zomba central hospital had six patients and five of them came from Mangochi district. In the northern region there were no specific areas where the patients came from.

2.5 Training

A one-week training was conducted at Nkhoma and Zomba hospitals. Dr. Kelly, a visiting surgeon from England facilitated the trainings. The gynaecologist from Kamuzu Central hospital and some Taiwanese doctors from Mzuzu central attended the training. In Zomba it was difficult to establish who attended the

training, as there are no records. The hospital superintendent remembers that the training took place but could not remember who benefited and when the training took place. It was however established that the training was very short and not competency based and as a result the trainees did not gain the required skills.

On the job training is taking place in all hospitals visited. Some clinical officers are being trained on the job and some of them are able to do minor repairs.

All health institutions visited are prepared to offer structured training to health workers especially those working in theatre and in Post-operative wards. There is need to come up with a training manual before these trainings can be done. Below is Table 4 showing the number of staff that needs to be trained in each institution.

Table 4. Number of staff requiring training

	Medical doctors	Clinical officer	Nurses
Queen Elizabeth	7	5	10
Zomba		5	5
Mulanje Mission		0	0
Nkhoma Mission		2	3
Mzuzu Central		3	5
Ekwendeni		3	3
TOTAL	7	18	26

2.6 Reintegration of the patients after repair.

According to the health workers and the patients interviewed, the general feeling was that stigma is not a major problem. The patients with fistula are accepted by their immediate families mainly parents, sisters, children if available and cousins. It should be noted that this is not true with the husbands as most of them desert their wives. Out of the 21 patients found in the wards during the study, four had already been deserted by their husbands. After fistula repair patients are not referred for social services. The health workers indicated that once the patient is dry, everyone would accept her so there is not need for referral unless there are other problems such as a drop foot. In this case the patients are referred for physiotherapy.

2.7 Equipment and supplies

In the hospitals visited, fistula equipment is generally available. It is only at Queen Elizabeth hospital where there is urgent need for fistula equipment. Below is the status of equipment and supplies in each hospital.

Queen Elizabeth:

Currently the hospital has two fistula sets but the surgeon indicated that most of the instruments are his own and some of them need to be replaced. The hospital needs the following equipment:

- ❑ Strully scissors 22 cm.
- ❑ Metzenbaum T.C. Curved sharp 23 cm
- ❑ Mayo-Harrington curved blunt 20 cm.
- ❑ Standard curved sharp 23 cm (stitch scissors)
- ❑ Thorek scissors 23 cm.
- ❑ Angled scissors 22 cm.
- ❑ DeBakey atraumatic tissue forceps 20 cm.
- ❑ Tissue forceps (Waugh) fine teeth 20 cm.
- ❑ Allis tissue forceps 20 cm 2x
- ❑ Bozemann needle holder TC 23 cm
- ❑ Stratte needle holder TC 22 cm
- ❑ 2 Langenbeck retractor 8x 3 cm and 5.5 x 1 cm
- ❑ Dechamps ligature needle sharp right and left 20 cm
- ❑ Baby Dechamps ligature needle sharp right 20 cm
- ❑ Frazier suction tube
- ❑ Scalpel handle no 7 + Special very long handle 22 cm
- ❑ Probe (fine) and
- ❑ Metal catheter

In theatre, the bulbs are not working and the autoclave is also not working. As already indicated above there is only one theatre which is being utilized by seven surgeons and fistula is not given the priority it deserves.

Supplies such as antibiotics are available but the supply is inconsistent. The hospital needs urinary bags, spinal anesthesia, green material for theatre; catheters size 16 and 18, giving sets, dextrose in water and antibiotics such as chloramphenicol and ampicillin.

Zomba central hospital:

Equipment is generally available at the hospital; the hospital has three fistula repair sets. They however need supplies such as urinary bags, spinal anesthesia, green material for theatre, catheters size 16 and 18, ureter catheters size 20 and 30, colostomy bags, iodine and antibiotics such as amoxyl, metronidazole and ampicillin.

Mulanje Mission:

Mulanje Mission hospital will mainly require supplies such as catheters, green theatre towels, drugs and urinary bags. The visiting surgeon from Queen Elizabeth hospital conducts surgery so he brings the required equipment.

Nkhoma Mission Hospital:

Nkhoma Mission hospital will require mainly supplies such as catheters, green theatre material, antibiotics, anaesthetic drugs, gauze, cotton wool, IV fluids and urinary bags. The hospital has most of these supplies but they are not adequate.

Mzuzu Central Hospital:

The hospital has most of the equipment required for fistula repair. They lack tissue forceps, scissors 22cms, Mayo Harrington, the angled scissors and few other instruments. They are able to operate with the instruments that they currently have. The hospital also has adequate supplies, but lacks catheters, green material and pads.

Ekwendeni Hospital:

The hospital has almost all equipment and supplies required for fistula repair in adequate amounts. They only require additional antibiotics (Not specified)

2.8 External support

All hospitals visited are getting support from other countries for fistula services. It was however difficult to establish the amount of funding these hospitals are getting.

Queen Elizabeth Hospital is getting support from the Dutch government. The surgeon also gets some support from friends and the support he gets is in the form of equipment and supplies.

Zomba Central Hospital gets support from the Centre for International Migration (CIN). The hospital is supplied with equipment and supplies such as theatre tables and linen.

Americans are supporting Mulanje hospital but the support is in the provision of equipment and supplies meant for all patients and not specifically for fistula.

Nkhoma hospital is getting financial support from DFID and some of the funds are utilised for the fistula procedures as well as transport money for the patients. The hospital is also getting support from an American surgeon who provides supplies such as sutures. The visiting team was told that the support from DFID will soon end and the hospital will need additional support from the government or other donors.

Mzuzu hospital gets support from the Taiwanese Medical Mission and the support is in many different ways.

Ekwendeni hospital is getting support from the Presbyterian Church of Canada, Republic of Ireland and United States of America. Some of the funds are utilised as fees for the fistula patients.

2.9 Interviews with parents found in the ward

The team was not required to conduct some interviews but during the time of assessment 25 patients were admitted in four hospitals out of the six sites visited. The team that covered Southern region decided to conduct some interviews with patients. Below is the data for 18 patients who had complete histories taken.

Table 5: Age of patient at the time fistula occurred (in years)

Age of patient	Less than 18	18 to 20	21 to 25	26 to 30	Over 30	Total
No of patients	2	7	5	0	4	18

As can be seen from Table 5 above, 50 % of the patients were less than 20 years old at the time fistula occurred. This is the trend in all developing countries.

Table 6: Educational status in years:

	No education	Std 1 to 4	Std 5 to 8	Form 1 to 4	Total
Education	8	7	2	1	18

The table above confirms what has already been written in many countries that fistula patients are generally poor with no or very little education.

Table 7: Parity

	Para 1	Para 2	Para 3	Para 4	Para 5 and above	Total
Parity	8	3	2	1	4	18

Most of the patients had fistula during the first pregnancy (44%).

The main cause of fistula in the 18 patients was obstructed labour (15). 2 had surgical accident while in one patient fistula was due to cancer of the cervix. Those with surgical accidents, one had haemorrhoids removed and later ended up with a rectal vaginal fistula while the second patient had bladder stones removed and complicated to a vaginal fistula.

Of the 15 patients who developed fistula as a result of obstructed labour, delays occurred at all levels. Some patients delayed at home while others delayed at the TBA. The health centre also contributed as they did not refer patients in good time or in some cases the decision to refer was made in good time but transport was not available for the patients. For three patients delay also occurred at the

hospital. Some of the patients were actually waiting cases but the decision to take them for C/Section was made very late.

Table 8: Where delay took place

	Home	TBAs	Health Centre	Hospital	Total
Patient delayed	5	2	5	3	15

Below are three boxes showing profiles of three patients where delay occurred at home, health centre and hospital. Note that the actual names of the patients have not been used in order to protect their identities.

BOX3

Vena is a 23- year old woman who developed fistula during her second pregnancy. She has a 3-year old child that she delivered at home. When Vena became pregnant she attended antenatal clinic at one of the health centres in Blantyre. Labour started at home and after six hours when there was no progress a TBA was called. Unfortunately the TBA did not make the decision to refer her to a health centre but gave her 8 more hours for labour to progress. There was no progress and she was referred to a health centre which is very far from her home and she had to travel by the ox cart. She left her home at 4 am and arrived at the health centre at 12 mid day. She was then transferred to Queen Elizabeth central hospital where a C/section was done. Unfortunately Vena delivered a fresh stillborn. Despite an indwelling catheter Vena developed a fistula and also had a drop foot. Vena was not able to walk, physiotherapy has been done and now she is walking with some difficulties. Vena was discharged from hospital on 19 November 2003 and came back in September 2004 for fistula repair. The repair was done but was not successful. Her husband has since deserted her.

Below is another example of a patient who reported at the health centre in good time but delay occurred at the health centre.

BOX4

Mada is over 30 years old; she is a gravida 6 para 5 all the 5 children are living. Mada stays very close to a CHAM health centre. She went to the health centre the moment she realised that labour had started but at the health centre she was told that she was not in established labour and was told to wait. She spent her second and third day at the health centre with no progress. She knew that she was in labour but the midwife told her that it was false labour. On the fourth day she became restless, an ambulance was then called and she was taken to Mangochi hospital where an operation was done. A fresh stillborn was extracted. She became incontinent soon after the operation and she was later discharged home with an indwelling catheter. The catheter did not improve the situation. Mada went to Mangochi hospital four times before she was seen by the surgeon. During the Needs assessment Mada had just been operated. Mada has a 10-year old girl who has just been pulled out of school to take care of her sick mother in hospital. She still has her husband and he is the one who is looking after the other children at home.

Below is the case where delay occurred at the district hospital.

BOX5

Naphiri is a 20-year old woman who delivered at one of the district hospital on 28 March 2003. This was her first pregnancy and was told to come and wait in the hospital. Naphiri spent two weeks as a waiting case at the hospital. Labour started on 27th and she was done a C/section on 28 March where a fresh still-born was extracted. After removal of catheter she started leaking urine and was told to go home and that leaking would stop gradually but that did not happen so she went back to hospital in June 2003. She was then referred to QECH where she was told that she had two fistulas. One was operated last year and she is in the hospital for the operation of the second fistula. The first operation assisted her, as she is not leaking as much as she was leaking before. She still has her husband.

3.0 Conclusions

The Needs Assessment shows that fistula services are available in the six sites visited. The southern region is adequately covered with both static and outreach services but the coverage in central and northern regions is poor

Fistula services are provided free both in the government and CHAM institutions. There is however a fear in the CHAM institutions that it will be difficult for them to sustain services if the donors supporting them decide to pull out.

Guidelines for both pre- and post-operative care are not available. Different institutions are using their own systems and giving patients different type of information.

Only three surgeons had a formal training on fistula repair, the rest were trained through On-Job Training.

Generally fistula equipment is available in the institutions visited although not in adequate supplies. It is only Queen Elizabeth Central hospital that is in dire need of equipment. Supplies such as drugs, catheters, urinary bags and cotton wool are not readily available.

Two institutions, Zomba and Nkhoma conducted training for health workers in fistula repair. A number of officers were trained but the training was very short and theoretical and as a result no skills were gained.

Most of the fistula patients are found in the Southern region and Mangochi district is found to have more patients than the other districts. The fistula patients in Mangochi, Balaka, Machinga and Zomba will soon have no access to fistula repair services as the surgeon who was repairing fistulas in Zomba is leaving.

Just like in any African country, fistula patients are poor, uneducated, young and most of them pregnant for the first time.

Delays for care occurs at all levels, at home, at TBAs, at the health centre and in hospitals. Patients are not guaranteed of quality care as some of the patients who developed fistula were waiting mothers.

4.0 Recommendations

Short term recommendations: Service Delivery

- ✓ Ministry of Health should identify an obstetrician/gynaecologist with fistula repair skills to be sent to Zomba Central hospital to replace the surgeon who is about to leave.
- ✓ Delivery of fistula services should be done in the following hospitals: Queen Elizabeth Central Hospital, Zomba central Hospital, Mulanje Mission Hospital, Chiradzulu District Hospital and Thyolo District Hospital in the south, Nkhoma Mission Hospital and Lilongwe Central Hospital in the centre and Mzuzu Central Hospital and Ekwendeni Mission Hospital in the north. Chiradzulu and Thyolo have new well-equipped hospitals that should be utilised to reduce the congestion at QECH. These hospitals are very close to QECH, 30 to 45 minutes drive.
- ✓ Most of the fistula patients in the southern region are coming from Mangochi district. It is being recommended that the staff at Mangochi hospital should be trained to do minor repairs and a surgeon should visit them monthly to conduct major repairs. A medical officer or clinical officers should be targeted for the training.
- ✓ The Reproductive Health Unit, with support from the Fistula Task Force members should develop guidelines for pre and post op care of fistula patients.
- ✓ UNFPA and other donors should procure equipment and supplies for fistula repair in the identified hospitals.
- ✓ Fistula repair should be part of the Essential Health Care Package delivered at a health facility free of charge.

Short term recommendations: Training

- ✓ The Reproductive Health Unit, with support from obstetricians/gynaecologists should develop a training manual for fistula management. There is need to look at the training manuals available in the region such as the Kenya Machakos manual and the Tanzania manual and adapt it for Malawi.
- ✓ Ministry of Health should identify doctors and clinical officers who are interested in fistula repair to be trained.

- ✓ A training should be arranged for 10 clinicians and 10 nurses. The training should be competency based hence should be conducted at one of the major hospitals preferably Queen Elizabeth Central Hospital.
- ✓ Each district should recruit fistula cases for repair during the training course by creating awareness on obstetric fistula in the communities. Community Based Organisations and TBAs could be utilised to identify the cases for repair.

Medium to long-term recommendations

- ✓ The Ministry of Health should urgently develop a strategy for the prevention of fistula that should include awareness creation on the causes, predisposing factors of fistula and how to minimise them. This should be for all members of the society such as health workers, traditional birth attendants, traditional healers, school children, community leaders and the general population.
- ✓ There is need to conduct community awareness meetings on fistula so that patients are aware that fistula repair are provided free.
- ✓ Ministry of Health with assistance from donors should consider construction of an operating theatre at Queen Elizabeth Central Hospital.
- ✓ Ministry of Health should consider coming up with a centre of excellence where difficult fistula cases can be referred.

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List of people interviewed

NAME	CADRE	PLACE
Dr. Wischert	Gynaecologist	Zomba Central hospital
Mrs. Beatrice Nyirongo	Sister In-Charge	Zomba Central hospital
Dr. Y. Rijken	Gynaecologist	Queen Elizabeth C. Hospital
Dr. F. Sungani	Gynaecologist	Queen Elizabeth C. Hospital
Mrs. I. Matola	Matron	Queen Elizabeth C. Hospital- Gogo Chatinkha
Dr. Sue Makin	Gynaecologist	Mulanje Mission hospital
Dr. Ter Haar	Medical Doctor	Nkhoma Mission Hospital
Dr. Linden	Medical Doctor	Nkhoma Mission Hospital
Mrs. Edna Ngwanda	Matron	Nkhoma Mission Hospital
Dr. P. Jeke	Medical Doctor	Mzuzu Central Hospital
Dr. P. Daza	Medical Doctor	Mzuzu Central Hospital
Mr. Albert Nyirongo	Chief Clinical Officer	Ekwendeni Mission Hospital