

FISTULA SURVEY REPORT

REPRODUCTIVE UNIT
MINISTRY OF HEALTH AND SANITATION

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FISTULA MAPPING SIERRA LEONE- DECEMBER 2004

1.0 INTRODUCTION

Obstetric fistula is a “false communication” or hole that is formed between the vagina and bladder (vesicular-vaginal) or vagina and rectum (recto-vaginal) of a girl or woman during a difficult childbirth primarily as a result of prolonged and obstructed labour when the head of the baby cannot pass easily through the birth canal of the mother. Obstetric fistula is a critically important but largely neglected issue in the field of reproductive health.

The World Health Organisation estimates that between two and four million women currently live with one form of fistula and that an additional 50,000 to 100,000 are newly affected each year. For the vast majority of women and girls who suffer from fistula problems, services to repair their condition remain unattainable for a number of reasons namely:

- ❖ Their lack of knowledge that such a condition can be repaired
- ❖ The distance they must travel to reach a facility which provides treatment
- ❖ The low likelihood that, even if they can get to a facility fistula repair services are available.
- ❖ Their inability to pay for the services if they are available and
- ❖ The backlog with which facilities that do provide repairs are faced.

The physical and social impact of fistula on the lives of women and girls requires immediate attention to the condition. The most immediate physical consequence of fistula is leaking of urine and/or faeces continually through the vagina, resulting in constant wetness and smell. Fistula can also cause ulceration of the genital area from leaking as well as a number of other difficulties. An unrepaired fistula apart from giving rise to continuous leakage of urine also makes such women susceptible to urinary tract infections, virginities and other complications. They are not welcome among their people because they smell, not permitted to

leave with their husbands and thus become social outcasts. The social effect could be most severe for such women living especially in traditional rural settings resulting in the breaking down of marital homes, and loss of means of sustenance. Childlessness is also often common among such women.

- A service challenge for health and reproductive services is the social rehabilitation of women even after a successful repair. In African countries where most of the clients are extremely poor, they are often abandoned by their husbands or partners. Furthermore, as they do not possess the skills to earn a living on their own, they are therefore rendered especially vulnerable.

- In Sierra Leone the number of women and girls living with fistula is not known nor is the geographic distribution of the condition. However, it is believed that many more women and girls suffer from fistula condition than is seen at the hospitals which report their data.

The survey data from the PCMH showed that fistula was most common among young adult females between 15 and 30 years old although the condition was seen in young girls between 10 and 14 years old and in a few older women between 34 and 44 years old. The patients were mostly referral from the rural areas and are characterised by extreme poverty, largely illiterate and are totally economically dependent on their husbands and spouses who survive on subsistent farming in the rural areas. The vast majority of the patients were found to be Muslims. The religious upbringing of the patients has been found to act as a barrier in the number of cases as it prevents patients from seeking health care services from hospitals and other institutions especially for male doctors preferring instead to consult traditional birth attendants and other local traditional healers.

1.1 The Fistula Mapping Survey

In December 2004, a team of twelve data collectors, guided by two assessment team members visited a number of selected health facilities to gather data on

- Situation Analysis of the RH Services in Sierra Leone
- An assessment of emergency obstetric services in Sierra Leone
- Obstetric Fistula mapping exercise.

1.2 Selection of Facilities

Relevant data were collected from all districts/provincial and other hospitals (NGO and faith based) identified in each of the 13 districts including the Western Area, and two (2) peripheral units consisting of one health centre and one MCH post in each district.

Details of the survey methodology are presented in the other segments of the REPRODUCTIVE HEALTH SURVEY to follow.

In all a total of 18 hospitals, 28 health centre and MCH posts were included in the survey. Specifically, the fistula mapping exercise sought to collect data on

1. The hospital/HC or MCH post currently undertaking fistula repairs or are referring patients to other facilities for care.
2. Facilities where doctors with specific training in fistula repairs are located.
3. Facilities with staff that could be trained for fistula repairs.
4. Availability of equipment and supplies at facility to do fistula repair.
5. Needs in terms of policy advocacy
6. Recommendations for prevention and management of fistula.

2.0 Major Findings

The findings given in this survey do not represent the number of women and girls living with fistula in Sierra Leone, nor do they represent the geographic distribution of fistula cases throughout the country.

Although peripheral health facilities (health centres and MCH posts) were included in the general survey, data from these institutions are however, unavailable as none of these institutions reported any activity relating to fistula.

The extent of fistula is not known in Sierra Leone since no community prevalence studies have been done. The data presented in this report are hospital based and should therefore be interpreted cautiously bearing in mind the limitations of such data as they are very likely to seriously under estimate the problem. The purpose of this report is therefore to identify major gaps in the fistula services throughout the country and to make recommendations for the prevention and management of fistula.

2.1 Hospitals Conducting Fistula Repairs

Of the 18 hospitals surveyed (13 urban, 5 rural) 6 reported that they did some fistula repair. Apart from the PCMH the number of fistula repairs done in the other 17 hospitals could not be obtained due mainly to a reluctance on the part of the staff in order to avoid responsibility for the consequences of failure. However, it was reported that only one or two repairs were undertaken in the other hospitals during the past twelve months leading to the survey period. With the exception of the PCMH the other hospitals, Kambia Government, Koidu, Pujehun, Kenema and Bo Government hospitals are located in the rural areas (see table 1). Only the PCMH, however has a medical doctor and a nurse trained to do fistula repairs.

Table 1

**Hospitals which conducted fistula repair in the period October 2003 –
November 2004**

NO	HOSPITAL	LOCATION
1	Princess Christian Maternity	Freetown (Western Area)
2	Kambia Government	Kambia District
3	Koidu Government	Kono District
4	Pujehun Government	Pujehun District
5	Bo Government	Bo District
6	Kenema Government	Kenema District

Table 2:
List of hospitals surveyed

NO.	HOSPITAL	TYPE OF OWNERSHIP	LOCATION
1	PCMH	Government	Freetown (Western Area)
2	Rokupa	Government	Freetown (Western Area)
3	Waterloo Community	Government	Waterloo (Western Area)
4	Bo	Government	Bo District
5	Lungi	Government	Port Loko District
6	Makeni	Government	Makeni (Bombali District)
7	Magburaka	Government	Magburaka (Tonkolili District)
8	Kabala	Government	Kabala (Koinadugu District)
9	Koidu	Government	Koidu (Kono District)
10	Pujehun	Government	Pujehun District
11	Kailahun	Government	Kailahun District
12	Moyamba	Government	Moyamba District
13	Kenema	Government	Kenema District
14	Kambia	Government	Kambia District
15	Bonthe	Government	Bonthe District
16	UBC	Faith Based	Mattru (Bonthe District)
17	Mabeseneh	Faith Based	Lunsar (Port Loko District)
18	Marie Stopes	NGO	Freetown (Western Area)

From available reference materials it is generally reported that between 10-15% of all VVF cases are associated with RVF and that isolated RVFs are rare. A number of RVFs are often left after inadequate repair of obstetric tears through to the rectum. However, these fistulas are small and in isolation are not usually associated with the same mortality and morbidity as an RVF associated with a VVF. Since the majority of true RVFs which occur as a result of obstructed labour are associated with a VVF, the total number of VVF alone (without adding the number of RVFs to the total) would represent the total number of women and girls affected by fistula.

Although five hospitals (all outside Freetown) apart from the PCMH reported that they did perform some fistula repairs, the exact numbers could not be obtained either due to reluctance of the respondent to disclose the numbers or that records were not available.

Similar problems regarding disclosure of information were encountered at the PCMH. It was, however, reported that a total of some 170 repairs were done in the 12 month period November 2003 – October 2004 with a success rate of 95%.

2.2 Hospitals able to receive a Visiting Surgeon to do occasional Clinic

Of the 18 hospitals surveyed 16 (88%) reported that they were in a position to receive a visiting Surgeon to carry out fistula repairs. Apart from the PCMH, the Marie Stopes Clinic and the Rokupa hospital, all the other hospitals are located in the rural areas and they include the provincial hospitals at Bo, Makeni and Kenema. According to reports by the hospital staff interviewed, the hospitals that are able to receive a visiting surgeon to do occasional fistula repair are listed in Table 3. This decision was based largely on the availability of human resources and also on the limited availability of equipment and supplies.

The ability of the 16 hospitals to exercise the function of fistula repair varied among the institutions. Some institutions like the Marie Stopes and the Bo Government Hospital have adequate number of physicians and nursing staff as

well as equipment to provide back –up for a visiting surgeon. Others like Waterloo and the Koidu Government Hospitals are in a less favourable position with regard to staffing and equipment supply.

Table 3:

Hospitals which reported “able to receive a visiting surgeon to do occasional clinic” (excluding the PCMH)

NO	HOSPITAL	OWNERSHIP	TOWN/DISTRICT
1	Rokupa	Government	Freetown (Western Area)
2	Waterloo	Government	Waterloo (Western Area)
3	Bo	Government	Bo (Bo District)
4	Lungi	Government	Lungi (Port Loko District)
5	Makeni	Government	Makeni (Bombali)
6	Magburaka	Government	Magburaka (Tonkolili)
7	Kabala	Government	Kabala (Koinadugu)
8	Koidu	Government	Koidu (Kono)
9	Pujehun	Government	Pujehun District
10	Moyamba	Government	Moyamba (Moyamba)
11	Kenema	Government	Kenema (Kenema)
12	Kambia	Government	Kambia (Kambia)
13	Bonthe	Government	Bonthe (Bonthe)
14	U.B.C. Mission	Mission (FB)	Mattru (Bonthe)
15	Mabeseneh	Mission (FB)	Lunsar (Port Loko)
16	Marie Stopes	NGO	Freetown (Western Area)

2.3 Availability of Specialist Surgeon and Obstetrician/ Gynaecologist/ Urologist

Of the 18 institutions surveyed only eight (8), i.e.44% reported that there was a specialist surgeon or obstetrician/gynaecology at the facility who could be trained to do fistula repair. From the responses it would seem that large provincial hospitals already with some specialist staff and some NGO- supported facilities are in the position to provide qualified staff for specialised fistula training.

The dearth of specialist doctors currently in the country is reflected in the shortage of specialists that can be trained to do fistula repairs. Of the 18 facilities surveyed

14 facilities had no obstetrician/gynaecologist;

3 facilities had only 1 obstetrician/gynaecologist and surgeon each;

1 (PCMH) had 5obstetrician/ gynaecologists and 7 medical doctors.

The paucity of other cadres of trained staff is also reflected in the poor availability of postoperative staff. With regard to the availability of specialist, obstetrician/gynaecologists and postoperative staff, the PCMH enjoys a very significant advantage over the other facilities. Consequently the PCMH is the only facility that offers fistula repairs on a full-time basis. It is also reported to have adequate and readily available equipment and supplies to perform fistula repairs. All patients are admitted in a separate 20 bed ward in the hospital. Apart from this 20 bed ward there are no other facilities available for fistula patients.

2.4 Cost of Fistula care and Exemptions

The actual cost of performing a fistula repair in facilities may be difficult to ascertain and besides may vary between that of an NGO and a Government-owned institution. However, it is estimated to vary between Le600, 000 and Le900, 000. The PCMH and the Bo Government hospitals reported that they provide some level of exemption to patients who could not afford the full cost of

repairs and that the charges are largely for the cost of blood for transfusion and other medical supplies and not as doctor's fees.

At the PCMH, cost charged to patients is reported at approximately Le360, 000. This cost is heavily subsidized by the IMC.

2.5 Training

The PCMH could be regarded as a national referral centre for fistula repairs. A hospital ward with 20 beds has been set aside. A national doctor trained in fistula repairs works full-time at the centre, another national obstetric/gynaecologist specialist with some training in fistula repairs also works part-time at the facility. Two nurses were also trained in post operative management of fistulas although only one of the nurses is reported to be at post at the time of the survey. Both nurses and the doctor were trained at the Evangel VVF centre in Jos, Nigeria.

Between the years 2002 and 2003, a number of in-service training programmes related to fistula management were conducted for doctors and nurses at the hospital. (see Annex for list of training courses conducted).

2.6 Needs in Terms of Policy Advocacy

Discussions with some MOHS officials indicated the common desire to strengthen other facilities apart from the PCMH, for fistula management.

Qualified staff, including doctors and nurses would be recruited and trained in fistula management and posted to the major provincial and district hospitals of Bo, Kenema, Magburaka, Makeni, Koidu and Kabala. Other hospital would be upgraded to provide the capacity for visiting specialist to perform fistula operations.

3.0 RECOMMENDATIONS

It is to be stressed that the data presented in this report neither represent the total number of women and girls suffering from fistula nor the geographic distribution of fistula cases. Furthermore, the information obtained at the time of the survey may have changed due to staff movement.

Caution must therefore be exercised in using the information provided in this report about the extent of the fistula problem and the scope for management especially outside Freetown. There is considerable secrecy and stigma which prevent some women from reporting and also some health personnel from reporting the extent of their involvement in fistula management. The reason for the latter may be an attempt to protect these personnel from accusations and responsibility for any failure that may arise.

Furthermore, it is to be noted that some of the information provided may need to be regularly updated due to the re-assignment of doctors and other staff consequently altering the already sparse availability of fistula service especially in the rural areas.

The data indicate that only 6 hospitals throughout the country performed fistula repairs – PCMH, Bo, Koidu, Pujehun, Kambia and Kenema.

The PCMH is the only facility that could boast of a trained staff and adequate essential infrastructures for fistula repairs and management. The hospital has facilities for both comprehensive and emergency obstetric care and has also acquired considerable experience in the management of fistula cases. It could therefore be strengthened to serve as a national referral centre for fistula management. For the hospital to perform this function the following will be needed:

- ❖ more doctors and specialists trained in fistula repairs.
- ❖ more nurses trained in post-operative care of fistula patients.
- ❖ hostel accommodation for fistula patients.
- ❖ adequate essential equipment and supplies.

The staff of other hospitals which reported to have done some fistula repairs should be identified and provided with the opportunity for specialised training in fistula repair. The three hospitals (Koidu, Pujehun and Bo) are in large district towns where rebel atrocities were committed on a large scale and the demand for fistula repairs is presumed high. Additional hospitals in Kenema, Makeni and Kambia which already have some basic capacity are located in under-served areas of the country and together with the other hospital in Koidu, Pujehun and Bo, would form a second tier of hospitals in the short-term to provide surgical care for patients with less severe forms of fistula. The remaining provincial/district hospitals when upgraded and equipped would also serve as second tier hospitals for fistula repairs.

3.1 Management of fistula at the Community Level

The prevention of fistula and the improvement of fistula services can be undertaken at the community or primary health care level. A necessary intervention is continued training in safe emergency obstetric care that minimizes unrecognised and/or untreated obstructed labour, which is the primary cause of fistulas. This education and training could be provided by a visiting RH Team and supplemented through the distribution of training material.

Management of fistula at the community or primary health care level will therefore constitute the first tier of fistula management.

It will be necessary also to educate health care providers at every hospital and clinic performing obstetric care on the prevention of fistula in patients, such as early catheterization and adequate fluid intake by fistula patients. Health education programmes in primary health care facilities should also be

implemented and social integration could be implemented through skills training and the creation of job opportunities for fistula patients after a successful fistula repair.

3.2 Ensure Accessibility of Care for every Fistula patient

Due to the paucity of fistula management services (centres and trained staff) it is understandable that women who suffer from fistulas have limited access for such facilities. This is compounded by the fact that these women are generally extremely poor to afford the cost of fistula repairs. Poverty, among fistula patient especially those from the rural areas, was found to be of high prevalence.

Affordable and sustainable mechanism for financing fistula repairs must also be established. Furthermore information about such services should be widely disseminated.

In summary the following structure is recommended for the management of fistula.

3.3 First level of Management: The community or primary health care level.

At this level basic emergency obstetric services will be strengthened by the training of staff in timely diagnosis and appropriate management, and prevention of fistula. Information on fistula should be widely disseminated in the community.

3.4 Second level of Management

Hospitals already with basic capacity especially those in areas where rebels committed wide-scale atrocities and those in underserved areas of the country will be strengthened with equipment and training of staff to enable these hospitals to perform regular fistula repair. Hospitals at the second level of management would assess women and treat those who could be successfully operated on at the hospitals and also decide which women would need to be referred to the PCMH. To fulfil this condition a reliable ambulance service with some financial assistance to the patients is needed. Those hospitals which

would constitute the second level of management will be selected from the list of facility presented on Table 3. Criteria for selection of these hospitals should be based among other things on location and ability to serve underserved areas, availability of human resources, equipment as well as the capacity to receive visiting specialist. Staff of these hospitals will be provided with the opportunity for training through local training such as such period of internships.

These hospitals include, Bo, Kenema, Koidu, Pujehun, Makeni and Kambia. The other district hospitals will also become part of the second tier after capacity has been strengthen at these facilities. They should also be equipped to receive visiting experts to conduct clinics.

3.5 Third Level of Management

As the findings indicate the PCMH is already performing a significant number of fistula repairs annually and is also serving as a national referral centre for fistula management. The hospital should be provided with additional facilities – trained staff (doctors, nurses) equipment and other medical suppliers.

The following IEC/BCC campaigns are recommended:

Create awareness and disseminate information to communities and health care providers at all levels.

Disseminate accurate information on fistula and fistula services at all levels particularly for young girls and women in the rural areas. Such information should be transmitted in the main local languages to enable as wide an audience as possible. This information should up-date girls and women on the causes and services available for fistula. This should be integrated with other information such as pregnancy, child birth, post partum care and other RH services.

Annex A

IMC TRAINING AT PCMH: JULY – SEPTEMBER 2002

#	Course Participants	Training Topic(s)	Type of Training	No. of Participants		Course Duration
				Female	Male	
1	National Doctors	Ureteric injuries, postoperative position of the patient, reimplanation of the ureter to the bladder	On-the-job	2	1	6 sessions
2	National Doctors	Infection Prevention-identification and catheterization of ureters during fistula operations	On-the-job	2	0	6 sessions
3.	National Doctors	Types of flaps of fistula repair, uretero-neocystostomy, intraoperative identification of the ureter (ureteric catheter technique)	On-the-job	1	0	4 sessions
4.	National Nurses and Paramedical Staff	Recording urine output, vagino-plasty treatment, colostomy tretatment	On-the-job	21	0	5 sessions
5.	National Nurses and Paramedical Staff	Infection Prevnetion, Preoperative nursing and postoperative care	On-the-job	22	0	8 sessions
6.	National Nurses and Paramedical Staff	Case history taking, clinic registration, infection control	On-the-job	28	0	5 sessions

Annex B

IMC TRAINING AT PCMH: OCTOBER 2002 – FEBRUARY 2003

#	Course Participants	Training Topic(s)	Type of Training	No. of Participants		Course Duration
				Female	Male	
1	National Doctors	Intraoperative diagnosis of vesicocervical fistula, reconstruction of vagina during VVF surgery, using omental flap during abdominal repair of vesicouterine fistula	On-the-job	1	0	4 sessions
2	National Doctors	Selection of cases for urine diversion, choosing type of urine diversion, retroperitoneal and intraperitoneal dissection of the ureter	On-the-job	1	1	3 sessions
3	National Doctors	Complications of postoperative blood transfusion, management of acute post transfusion renal failure, indications of FC flap and uses of different flaps in VVF repair	On-the-job	1	1	4 sessions
4	National Nurses and Paramedical Staff	Proper use of medication chart, how to manage blocked Foley's catheter, management of failed deflation of the balloon catheter for removal	On-the-job	12	0	3 sessions
5	National Nurses and Paramedical Staff	Uses of IV fluid chart, postoperative care of the FC flap patients, nursing of acute renal failure patients	On-the-job	21	0	3 sessions
6	National Nurses and Paramedical Staff	Safe blood transfusion, postoperative haematuria (causes and management), use of triple-way catheter in postoperative bladder wash	On-the-job	12	0	3 sessions

7	National Doctors	Labia majora flap/FC flap to cover the lateral vaginal wall, Mainz pouch II techniques , post operative urethral stricture after VVF	On-the-job	1	1	4 sessions
8	National Nurses and Paramedical Staff	Proper use of medical chart, post-op-care of labia majora flap patients, nursing patients with ureteric catheters, removal of catheters	On – the- job	20	3	4 sessions