Report of visit to Selian Lutheran Hospital, Arusha, Tanzania (19 7.12 – 5.8.12) and Kitovu Mission Hospital, Masaka, Uganda (5.8.12 – 19.8.12)

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Purpose of visit

To improve surgical skills in management of patients with obstetric fistula and to learn from established units about the running of a designated fistula unit providing pre-operative assessment, surgical treatment and post-operative care.

Background

I have been working with the International Nepal Fellowship, an interdenominational Christian organisation as an obstetrician/gynaecologist in western Nepal since 2003. In the course of my work I infrequently encountered patients with obstetric fistula. Until recently the only hospital in Nepal providing a service for fistula patients was Patan hospital, Kathmandu. Since 1987 some 400 patients had been treated at Patan and it was believed that obstetric fistula, while a devastating condition for the individuals affected, was not a significant public health problem in Nepal. To provide a service for fistula patients in the west of the country I needed to learn to operate for complicated fistula.

In 2008 I spent 4 weeks at Bahirdar Hamlin Fistula Unit in Ethiopia, learning from Dr Andrew Browning MRCOG. Since then I have organised and run 4 fistula repair camps at the Mid-West Regional hospital in Surkhet, Mid-West Region – my base in Nepal. I have been grateful for the support and assistance of Dr Mike Bishop at the past 3 camps. Mike is a UK trained urologist who has now retired from urology practice but travels to several countries for fistula surgery. To identify women with fistula an awareness-raising and fistula prevention programme has been run in many of the districts of Mid-West and Far-West Nepal and we will continue until we have covered all the districts in the three western regions. We discovered that rural health post workers had no knowledge about obstetric fistula and, having received the training, they are identifying and referring increasing numbers of patients. We have treated over 100 patients through the 4 camps.

UNFPA have been developing a Stop Fistula in Nepal Campaign and organised an Obstetric Fistula Needs Assessment and coordinated efforts to manage the fistula patients in Nepal. The camps at Mid West Regional Hospital in Surkhet have been identified as the Fistula treatment Centre for women living in the western half of the country. This led to recognition of the need to increase our capacity to provide surgical treatment to meet the growing demand. We have plans to build and develop a designated fistula centre within the Mid West Regional hospital complex that will provide training of Nepali fistula surgeons and nurses and will provide surgery throughout the year. The visit to Tanzania and Uganda was arranged to assist in the preparation for the fistula centre.

Selian Mission Hospital, Arusha

Selian hospital has been developed by the Lutheran mission from a small health post to a busy general hospital. Dr Andrew Browning moved there from Ethiopia 3 years ago, appointed as consultant obstetrician and gynaecologist, to develop fistula services at the hospital. He has been surprised by the small numbers of fistula patients he has seen in Northern Tanzania despite all outreach activities and a network of fistula advocates. This is in sharp contrast to the experience in Uganda where despite many
years of fistula surgery and training and a reasonable road system and hospital network able to provide 
caesarean section, many patients with fresh fistula are seen. The majority of the Ugandan patients have 
been delivered by caesarean section but usually after 2 or 3 days in labour. In Tanzania there is a high 
literacy rate and free obstetric services. In Uganda there are fees for maternity services and it seems 
likely this is a factor in a patient’s decision to attempt home delivery, leading to late presentation in 
obstructed labour. In Nepal we have seen a sharp rise in institutional delivery since the introduction of 
free maternity care with provision of a small financial incentive to assist patients with travel cost.

There were only 3 patients with fistula and one patient with severe stress incontinence operated during 
the 2 weeks I spent at Selian hospital. One had a high utero-vesical fistula, one a ureteric fistula following 
abdominal hysterectomy both of which Dr Browning repaired vaginally. The third was a 21 year old, Para 
3, with a large circumferential juxta-urethral fistula which I had the opportunity to repair. This type of 
complicated fistula is one we see frequently in Nepal and I was grateful for the opportunity to operate 
under the guidance of Dr Browning. Stress incontinence is common following repair for this type of injury 
because the urethra is much shortened and denervated. Dr Browning has developed a technique of 
making a sling from the pubo-coccygeus muscle at the time of fistula repair which provides support to the 
delicate repair of urethra to bladder as well as significantly reducing the incidence of post-operative 
stress incontinence.

I was able to discuss some of the difficult cases I have tried to manage in Nepal. In some patients with 
large double fistula there has not been sufficient vaginal skin to cover the bladder or bowel repair and 
these patients have done badly with failure of the repair. I have learnt, from tutorial and video, how to 
perform the Singapore flap, taking skin and subcutaneous tissue from the outer labia majora and 
tunnelling it through to cover vaginal skin defects.

**Kitovu Mission Hospital, Masaka, Uganda**

Kitovu Catholic Mission Hospital has been a centre for training fistula surgeons in Uganda for 25 years. 
The service began through Dr Maura Lynch and she continues to manage the fistula unit though not 
performing fistula surgery personally since losing the sight in one eye. Several very eminent visiting 
fistula surgeons conduct 4 training camps each year. 300-360 patients annually have surgery and to date 
31 local surgeons have received training though few of these are practising fistula surgery. This year a 3 
week camp was held from the 6th-26th August. On 17th and 18th August a workshop was organised by 
Shane Duffy, another of the regular visiting surgeons, to consider fistula training and research at Kitovu, 
past present and future, to discuss dilemmas and recent advances in fistula surgery and consider the 
future of Kitovu as a fistula centre in light of changes in funding and the emerging Ugandan National 
Training Guidelines and standards.

I participated in the camp for the first 2 weeks, working with Paul Flynn, consultant gynaecologist at 
Swansea. In the second week we were joined by Andrew Browning and Brian Hancock. We assessed over 
70 patients suffering urinary or faecal incontinence and in the first 2 weeks of the camp 56 patients had 
surgery. It was a huge privilege to work with Paul, Andrew and Brian and I am very grateful for all they 
taught me. I operated for 14 patients with vesico-vaginal fistulae and 4 with complete disruption of the 
anal sphincter. I joined Paul Flynn for reimplantation of ureter for 4 patients including one 11 year old girl 
with ectopic single right ureter.

Kitovu hospital has a very successful fistula unit with dedicated and skilled nurses who take histories, 
prepare, nurse and counsel the patients. With Dr Maura they care for the patients after the camp until 
ready for discharge and will follow up those who need further treatment. In Nepal, as organiser of the 
fistula camps I am able to see my patients through to discharge and follow up their progress through
telephone review at 3 and 6 months and at 12 months all are invited back for follow-up examination. In my experience so far about 50% have returned for this review. All the patients travel and living costs for the initial treatment and for follow-up visit are met through the fistula camp funds. Almost all who have not re-attended we have been able to contact by phone. Many who feel completely cured have preferred not to travel the long distance for review. It is disappointing that I will not know the outcomes of the operations I have performed in Uganda as this is very valuable in learning and developing as a fistula surgeon. It is not possible as each camp is conducted by a different team of visiting surgeons. I have benefitted greatly from working with the Kitovu nurses, seeing the organisation of the patients screening and their protocols for post-operative care and counselling.

It was also very useful to attend the 2 day workshop and learn from the Uganda experience about a training plan for national doctors and development of fistula services. It has been found that if where there are several centres, with surgeons managing only a small number of cases the success rate is lower and patients become discouraged. The first surgery is the most likely to be successful though many patients may need further procedures to manage stress incontinence. In Uganda it has been decided that fistula services should be concentrated in a few centres of excellence. Nepal is just becoming aware of the problem of obstetric fistula and Nepali gynaecologists are planning their response. I have been invited to be part of the Nepal Technical Working Group for obstetric fistula.

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I am grateful to the Royal College of Obstetricians and Gynaecologists for their financial support for this visit through the Bernhard Baron Travelling Fellowship award.

I am now much better equipped to continue in developing fistula services in Nepal through the fistula camps. I have learnt much that will allow me to operate on complicated fistulas with increasing success independently and will help me in planning and opening a designated fistula centre. This presentations and discussions from the Kitovu hospital workshop will be of great value in my new role in the Nepal Obstetric Fistula Technical Working Group and I hope that Nepal will benefit from the lessons learnt in Uganda over the past 25 years of conducting fistula training.