Are you working in obstetric fistula?
Do you have stories, ideas or projects you would like to share with us?
Please get in touch to tell us more - globalhealthinfo@rcog.org.uk
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Editorial

The British All Party Parliamentary Group on Population, Development & Reproductive Health named their report on global maternal morbidity, ‘Better off dead’ because of the often devastating morbidity suffered by women who survive complications of childbirth.

Welcome to International News

Having previously been a neglected area of women’s health, the problem of obstetric fistulae has, in recent years, gained the attention of the international health community with resultant improvements in funding and resource allocation. There is little data on the size of the problem, but for every woman who dies in childbirth there are at least 20 more that suffer from injury, infection and disability. It is estimated that two million women worldwide are living with obstetric fistula, mostly in Africa and the Indian subcontinent, with between 50,000 to 100,000 new cases occurring each year. Despite the increasing awareness of the burden posed by obstetric fistulae on maternal health and developments in services for repair, there remain many women who live in constant discomfort. They are often unable to participate in tasks of daily living or income generation and may be isolated and unaware that there is help available. They frequently face insurmountable barriers due to cost of treatment, transport, accommodation and food. It is for this reason we decided to dedicate a whole edition of RCOG International News to the subject of obstetric fistula and are immensely grateful to our contributors for their willingness to share their insights and experience.

This edition fittingly starts with accounts from women themselves who have suffered from fistula. We are very grateful to them for sharing their experiences so that we may learn more and spread the message that fistula is a truly awful condition that no woman should have to suffer.

We have also included a summary by Kathryn Siddle of two Journal Club papers on the psychosocial experiences of women with fistulae and their birth histories. Classically, we are taught that there are three points of delay in accessing assisted delivery – first, the delay in a decision to access care by the woman, her family or carers; second, the delay in reaching a health facility due to lack of transport and third, the delay in intervention having reached a health facility. In the second powerful paper Mselle and colleagues note that once the health facility is reached there is a subcategory, namely receiving correct care, either due to lack of skilled decision-making capacity, lack of will or low numbers of appropriately skilled personnel to deliver the required care.

Both papers illustrate that there is still a long way to go in treating and preventing obstetric fistula.

Following this, we have a selection of articles written by Members of the RCOG and RCS who are working in fistula around the world. Their insight is invaluable to understanding root causes and effects of fistula.

Michael Bishop shares an overview of obstetric fistula from his extensive experience as a consultant urologist working in fistula in Uganda, Sudan and Nepal and Shirley Heywood, who has developed fistula treatment camps in rural Nepal tells us of the difficulty in reaching women who have withdrawn from society because of their shame.
Obstetric fistula is the result of a failure of timely intervention in obstructed labour. It is a ‘near-miss’ maternal death. This lack of proper care and understanding occurs when a woman is at her most vulnerable, leading to extreme suffering in the short-term and long-term morbidity.

Andrew Browning, who worked for many years in fistula care in Ethiopia before moving to work in northern Tanzania, discusses the problem of residual incontinence following surgery to ‘close the hole’, most notably stress incontinence as a consequence of damage to the closing mechanism at the bladder neck.

The Hamlin Fistula Hospital in Ethiopia is world renowned as one of the leading centres for fistula repair and training. Jeremy Wright, who currently works there as a fistula surgeon tells us how the pioneering centre was established and paved the way to raise awareness of the condition and the needless suffering of women.

Our centre fold shines the spotlight on to Kitovu Hospital, Uganda; a centre for excellent fistula surgery and care. Kitovu and the RCOG are working together jointly to develop and expand its capacity to provide life-changing fistula surgery to more women all year round.

There are several fistula initiatives taking place to enable more timely access to quality health care and to training fistula surgeons.

Tulip Mazumdar, BBC Global Health Reporter shares her experiences of visiting Kitovu and how efforts are being made to change misconceptions and attitudes around fistula. She highlights how initiatives to improve timely access to fistula care, led by Mr Shane Duffy are giving more women their lives back.

Sohier Elneil, a consultant urogynaecologist at University College, London, gives a very useful update on the FIGO/RCOG and Partners “Competency-based Fistula Training Manual”. This programme is increasing the number of competent surgeons in countries where fistula is most prevalent.

Denis Robson describes how Johnson & Johnson’s initiatives and partnerships are enabling women better and faster access to health care to prevent fistula occurring. In addition, J&J are actively working with the UNFPA to help women reintergrate into society after undergoing a fistula operation.

The ‘TransportMyPatient’ initiative in Tanzania has enabled many more women to get to hospital more easily to be treated for their fistula and shows that harnessing mobile technology can be key to spreading awareness to women who are living in remote areas.

Looking to the future, Julia Irani reports on the research she has undertaken to investigate the experiences of women reintegrating into their local communities after fistula repair. Her work reminds us of the possibility and need for more research in the field of obstetric fistula, in order that services are evidence-based.

Finally, we are especially honoured to include Mr John Kelly’s obituary, kindly supplied to us by Mr Shane Duffy and Mr Kelly’s daughter, Mairead Kelly. Mr Kelly was a true pioneer in fistula care and was passionate about helping many hundreds of women who suffered from this terrible condition.

An expanded online version of this International News edition on obstetric fistula can be found at http://www.rcog.org.uk/book/international-news-sep-2012 containing news of several obstetric fistula centres around the world.

The mainstay of prevention is the provision of comprehensive maternity care with active management of labour, so that one day obstetric fistula will be a condition seen infrequently, as is now the case in the developed world. The solutions are complex and include strengthening of national health systems and infrastructure; prioritisation and governance of resources for maternal health; governmental support; individual, community and health professional education on fistula prevention; training in provision of fistula services; research to underpin evidence-based care; advocacy for women’s rights in accessing skilled and timely intervention where necessary during childbirth, along with a change in attitudes and expectations that fistula can be prevented, treated and eradicated.

Professor Alison Fiander FRCOG
Chair of Obstetrics and Gynaecology, Cardiff University, UK.
Co-editor RCOG International News and Chair
RCOG Global Project Development Committee.

Mr David Nunns FRCOG
Gynaecological Oncologist, Nottingham, UK.
Co-editor RCOG International News
and Chair RCOG Nepal Liaison group.
Introduction

The RCOG is taking a strong position in raising awareness of fistula prevention and cure.

By a twist of fate I happened to be born in New York City and it remains a special place for me to visit. After a recent trip I discovered that an entire block of Park Avenue, currently the location of the Waldorf Astoria, had been developed in 1867 as the site of the New York City Womens’ Hospital, responsible for treating thousands of women with obstetric fistula. The hospital closed in 1906 as fistula had been largely eradicated by modern maternity care.

Most people outside of our specialty will have never heard of obstetric fistula. In the developing world however over two million women continue to live with this condition. Indeed it is estimated that there are as many as 100,000 new cases each year while the current maximum capacity for repair is only 15,000 – the figures simply do not add up.

It is almost impossible to imagine the devastating physical and social consequences for a woman with a fistula. She is constantly wet, covered in urine and faeces. She develops sores caused by the urine and experiences pain during urination and intercourse. The smell leads to isolation; her community ostracises her and she lives in a permanent state of shame. She is unable to work and so cannot provide for herself and her family. The suffering is unimaginable and a woman with fistula can never lead a normal life again.

The WHO states that “Obstetric fistula still exists because health care systems fail to provide accessible, quality maternal health care, including family planning, skilled care at birth, basic and comprehensive emergency obstetric care, and affordable treatment of fistula.”

RCOG Fellows and Members are already providing excellent training through a variety of channels as well as giving the life-changing fistula repair operations to many hundreds of women through fistula camps. Our project at Kitovu Hospital, Uganda (see pages 20-21) is an initiative being developed by highly-experienced partners with a commitment to reducing the number of women suffering from fistula.

The RCOG is leading this project with the investment of volunteers, research and business strategies to develop Kitovu into a full–time fistula care provider:

Harriet, pictured opposite, underwent an operation to repair her obstetric fistula at Kitovu hospital. She suffered obstructed labour and as a result her baby died.

Since her fistula operation, Harriet has had four healthy children, delivered by Caesarean section. You can read more about Harriet’s story on the RCOG website on the RCOG website in the ‘Support our work’ section.

I hope that this special fistula edition of International News inspires you. Please join us in spreading awareness of this entirely preventable condition and ensure that obstetric fistula can become an historical condition for all women.
In their own words

Claire Herrick, MD
Obstetrician and Gynaecologist, Gallup Indian Medical Center,
Federal Indian Health Service, New Mexico.

Professor Alison Fniander FRCOG
Chair of Obstetrics and Gynaecology, Cardiff University, UK and
previously Technical Advisor, Obstetric Fistula Programme,
CCBRT, Tanzania.

Claire Herrick and Alison Fniander recorded the stories of
women with fistulae at the Comprehensive Community Based
Rehabilitation in Tanzania Disability Hospital in Dar es Salaam. Here, four of the women share their personal stories
of obstetric fistulae and the treatment they have received.

The Comprehensive Community Based Rehabilitation in Tanzania
(CCBRT) Disability Hospital in Dar es Salaam is one of the largest
hospitals in Africa dealing with disability. In 2002, CCBRT started a
fistula service, which is continuing to expand today. The community
of patients on the ward is in itself a source of healing for many. A few
years ago, women with fistulae began recording their stories to share
with women to come in the future at the suggestion of Claire Herrick.

Several patients offered to have their stories translated and shared
globally in order to raise awareness of fistulae across national and
economic borders and their stories are presented here. Most of
the patients have received no education or have only completed
primary school. You will notice that their language, Kiswahili,
has no punctuation marks, and is as written by the patients
themselves or another of the literate patients recording a story
for a fellow patient. We hope that the translation conveys the
correct meaning and have included a short medical summary.

In 2012 CCBRT introduced holistic care into its fistula service, which
included elements of health education, counselling, occupational
therapy, physiotherapy, singing and life skills. ‘Therapeutic story-
telling’ is now a regular activity on the fistula ward at CCBRT.

Naomi’s story

‘...you have had an operation, there is no baby,
and your urine is leaking all over. If you look at
everyone else, they have had their operations,
they have children, and urine is not spilling all
over them. I truly was in so very much pain.’

“Naitwa Naomi natokea mkooni Dodoma wiliyani Mpwapwa kata ya
berege kijji cha mkanana sina mtoto nimepata ugona huu kwa sababu ya
uzazi niliumwa uchungu tr 28 May 2011 asubuhu nikapelewka hospitali
ndogo kesho yakee 29 May 2011 asubuhu saa 3 nikashinda hapo nkalala
kesho yake 30 May 2011 nilishinda hapo mpaka saa 9 jioni wakapiga
simu hospitali ya wilaya mpwapwa gari kaja kunibeba gari nilifika saa

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'I felt like I was all alone suffering from this strange disease...I saw myself as having some kind of curse...'

Stella’s story

“I am Naomi. I am from Dodoma region, Tanzania, in the district of Mpwapwa near the village of Berege. I don’t have any children. I got this illness because of giving birth. My labour started in the morning of 28 May 2011. I was sent to the local hospital. The next day, 29 May 2011, I spent the whole day there. I was there through 30 May 2011 until 3 in the afternoon. They called the Mpwapwa District Hospital and an ambulance came to get me. The ambulance arrived at 5 pm and we arrived at 8 pm that night. I had an operation. The baby was lost. A catheter was put in me and left in for 9 days. The day it was taken out, I didn’t feel the urge to urinate. I went to the bathroom and squatted and the urine just came out for a long time. The second date, 11 June 2011, it started to spill. I told the nurse and she put in the catheter again. I heard that this condition, called VVF (Vesicovaginal Fistula) by the doctors, can be treated. The nurse called here to CCBRT on 28 June 2011. I travelled here. When I was in the hospital I was by myself. I cried a lot. Why is this urine just coming out by itself? It hurt me very much. You will see, you have had an operation, there is no baby, and your urine is leaking all over. If you look at everyone else, they have had their operations, they have children, and urine is not spilling all over them. I truly was in so very much pain. All the time, I was crying, I cried myself to sleep. I cried so much. When I arrived [at CCBRT] I found my fellows and I finally knew that I was not alone. Thanks very much.”

Naomi is 19 years old. She completed primary school and was working as a farmer when she went into labour with her first baby. After 2 days in a health centre she was transferred to a district hospital where she underwent Caesarean section for a stillborn baby. Her fistula was successfully repaired on 11 June 2011.

‘In my community I had become someone who just cries, but now since coming here to CCBRT I am at peace.’

“Mimi naitwa Stella nasanya nilipatwa na ugonjwa huu wa VVF baada ya kufanya oparesheni ya kutsaa umibe kwenye mfuko wa uzazi na kwenye mnja wa kushoto. Nilufanyiwa mwaka jana mwizi wa tano tatizo linianza siku ileile kwa sababu nilipokuwa nimewekwa mpira mkoko ulikuwa unamwagika kitandani baada ya kuruhisiwa nilkaa mezie nmitatu nikarudi tena nikoafanyiwa tena mwaka jana mwizi wa kumi tarehe 12 napa ikawa kama mwanza mwingine ulikuwa unapita kwenyewe mpira mweinge kitanani lakini niliruhisiwa hivyo hivyo moyo ulininiwa sana kwa vile sikupona nikaamua kurudi kijijini Mbaya-Mbozi baada.
My name is Stella. I got this condition called VVF after having an operation for fibroids in the uterus and the left fallopian tube. This was in May 2011. The problem started that very day, because when they put in the catheter, urine spilled all over the bed. After I was released, I waited for 3 months and then returned again. I had another operation on 12 October and it was like the beginning, some urine coming through the catheter and some spilling on the bed. But I was released like that. My heart hurt very much as I had not healed. I decided to return to my village. My little sister heard the radio announcement about the services at CCBRT and she sent me money for transport, so I came here. I am so grateful to her for sending me the transport money. When I was at home, I felt like I was alone in suffering from this strange disease. But when I arrived here, I found many like me and felt so much better. I have suffered so much, to the point that I saw myself as having some kind of curse. In my community I have become someone who just cries, but now since coming here to CCBRT I am at peace. I am grateful for the doctors’ services, receiving me here compassionately and lovingly. May God bless them very much, and continue to increase their knowledge and knowledge a hundred times over. My faith tells me that the surgery will be successful. Right now the urine bothers me a lot. Thank you very much.”

Stella is 31 and had a small business before her trouble started. She has never been pregnant and had a hysterectomy for large fibroids, which resulted in damage to her bladder and a vesicovaginal fistula. She had already had an attempted repair at another hospital but was left with a residual fistula. She was awaiting surgery when her story was written. Her operation was successful and she has gone on to the Mabinti project based in Dar es Salaam to learn vocational skills. While on the ward it was discovered that Stella had a gift for singing. She now returns once a week to give singing lessons to the patients on the WF ward.

Selestina’s story

‘I didn’t continue my studies because I got pregnant when I was at school.’


 ya kusikia tangazo kwenye rediokuhusu CCBRT kiume mdogo wangu akawa nayo beafu amesikia tangazo hilo na mdogo wangu kwa kutumia nauli nilipokuwa nyumbani nilijiona kama niko peke. Yangu mwenye kuwuka ugonjwa hua wa ajabu. Lakini nilipofika hapa nimewakuta wenzangu nimefarikika sana tena sana maana nemeteseke sana mpaka nilihisi kama nimepata mkosi gani katika jamii yaani nilikuwa ni mtu wa kulia tu lakini sasa tangia njike hapa CCBRT nijisikia amani kwanza napenda kushukuru kwa huduma zenu madaktari kwa kunipokea kwa moyo wa upendo mungu awabariki sana tenasana na mwenyezi mungu awoengezee uzuri mara mia imani yangu inamiasia kuwa pale mtakaponguza tu kibofu changu na kukishona nitapona tu vamhuku sasa mkoja unani uma kwenye kibofu naenda tu kukojoa ilia bado inatoka tofauti kwenye kibofu mwengi unatangulia ndio unanisumbua sana. Asanteni sana.”
Yusta had been leaking urine for 37 years before hearing that the condition could be treated.

“My name is Selestina. I am from Morogoro, in the village. I was in form 2. I didn’t continue my studies because I got pregnant when I was at school. When I delivered, I got a VVF. This was on 8 March 2011. I stayed over a month at the hospital. When I was released to go home, I had a VVF. I stayed a long time at home. When we heard that this condition of VVF is treated, I was very happy. I came to the hospital. The nurses welcomed me nicely and I was happy to see others with this condition. I am grateful to God and I am doing well. Since I got my operation, I am hoping I will be healed. Thank you all very much.”

Selestina is 16 years old. She became pregnant while still at school. She was in labour for four days in a dispensary before being transferred to the regional hospital where she underwent a Caesarean section for a stillborn baby. Her vesicovaginal fistula was repaired successfully on 12 July 2011.

Yusta’s story

“Naitwa Yusta natooka kigoma nilipata ugonjwa huu mwaka 1974 kwa ajili ya uzazi nilizao mtoto akaa bahati mbaya uliniama sana ukiangalia mtoto sikupata tena namepata VVF mwaka huu 2011 ndio nkasikia kwamba ugonjwa huu unatibwa nilisikia rediani nikaja hapo niliwakuta wenzangu wengi sana kwa kweli niifaliika sana niliyoto kuwa nyumbani niliona kama nipo peke yangu sasa hivi nipo kwene matibabu ninamatgemea nitapana kwa jina la yesu kwa kweli huu ugonjwa ni mbaya sana. Asanteni sana”

“My name is Yusta. I am from Kigoma. I got this condition in the year 1974 because of childbirth. I had a baby but it died. It hurt so much to look at children I didn’t have another. I got VVF. Then this year 2011, I heard that this condition is treated. I heard it on the radio, then I came here and I found many others like me. This was such a big comfort, as at home I had felt so alone. Now here I am after surgery, waiting to heal, praise Jesus. This is truly such a terrible condition. Thank you all very much.”

Yusta is 56 years old and from the west of Tanzania. She suffered an obstructed labour, aged 19. She spent two days at home before being sent to hospital where she underwent Caesarean section for a stillborn baby.

Although she says it hurt too much to have another baby, after a long gap she subsequently delivered six live children. She’d been leaking urine for 37 years before hearing that the condition could be treated. Although the fistula was closed, she was left with severe stress incontinence and asked to continue with pelvic floor muscle exercises. Upon review in clinic she continues to improve.
Women's fistula stories from Bangladesh

Dr Beatrice Ambauen-Berger, Head of Department and Consultant, Obstetrics and Gynaecology at LAMB hospital in rural Bangladesh.

Dr Jacqueline Hill FRCOG, Consultant Obstetrician & Gynaecologist, Bristol.

Dr Hill volunteered at LAMB as a 4th year medical student in 1989. She returned in 2013 as a senior consultant to teach, mentor and train junior doctors. Here, two of the women that have benefitted from fistula treatment at LAMB have given Beatrice their stories.

Yeasmin, 25 years

"When I was pregnant with my first child, the delivery started in our home. After 24 hours of labour pain the baby died in the womb. They took me to the hospital and there the baby was born normally. Because I was in labour for so long, I started leaking urine all the time. This lasted for two to three years.

I heard from a health worker about LAMB and they gave me money to come here. At LAMB I got well again. Three years later I got pregnant with my son. I went to LAMB and delivered the baby by Caesarean section. The baby was very small and got lots of care. Thanks to everybody's care and blessings he is fine to this day."

Nisemoni, 55 years

"I had two sons, then a third one came. I was three months into my pregnancy when my husband and I decided we did not want another child. After taking some roots, my waters broke and the baby was pulled out by hand from the uterus. There was lots of bleeding which went on for six months to a year, after that urine started leaking. Then my husband died and I did not have anybody to help me get treatment, so I raised my two sons on my own.

After 20 years I had a fistula operation, God has been very good to me and I am dry so far. I hope I will stay dry."

Nisemoni completed the six days CFA (Community Fistula Advocate) training (as part of LAMB's rehabilitation programme) six months after she was cured from her fistula. Now she is bringing many other fistula patients to LAMB and is boldly talking to people about how to prevent fistula from happening.

LAMB hospital welcome volunteers from all over the world and are currently looking for volunteers to help train junior doctors. If you are interested in finding out more please contact Dr Ambauen-Berger for more information: bea.xaver@gmail.com

"I am nothing": experiences of loss among women suffering from severe birth injuries in Tanzania

The following papers give interesting insights into the experiences of women suffering from obstetric fistulae. Dr Kathryn Siddle reviewed them while undertaking a final year elective spent at a fistula unit in Tanzania.

Lilian T Mselle, Karen Marie Moland, Bjørn Evjen-Olsen, Abu Mvungi and Thecla W Kohi

BMC Women's Health 2011;11:49.

In the analysis of the lived experiences from women affected by obstetric fistulae, four themes emerged: loss of body control, loss of social role as a woman, loss of integration in social life and loss of dignity and self-worth.

One woman described the loss of body control because of smell, wounds, pain and discomfort: "when you wake up all clothes are wet: when you work it flows on its own". This often led to the use of plastic shopping bags to prevent the urine dribbling down their legs, but which also caused painful skin erosions.

A 'shattered sex life' and inability to attend to daily commitments contributed to the loss of the social role as a woman and wife. One woman said 'since I got this problem, we have not slept together … and this is the most painful thing' and a husband portrayed the sex as 'dastasteful and unpleasant all the way through', with some husbands describing their relationship as like brother and sister, not husband and wife.

The loss of integration in social life frequently disrupted marriages and led to rejection by their husbands and other family members. One woman explained 'because I am leaking urine, I am useless, I have no value … my husband left me because I am leaking urine and I would not bear a child for him'. Frequently, fistulae led to infidelity by the husband, or a divorce/separation. Husbands felt pressure from the
community to divorce their wives as ‘the community will isolate the whole family’. Even within families, women distanced themselves, ‘at times even sitting with her children is difficult. She has turned into one who hides and runs away from others, sits alone.’ Some women were not allowed to cook for the family as ‘they see it as dirt’.

The loss of dignity and self-worth women experience results from increased dependence on others, especially regarding economic activities. The feelings of uselessness and self-contempt were powerfully expressed: ‘I am nothing, I feel like a child’.

The research concludes that obstetric fistulae represent a major physical, emotional and social problem for the women affected and suggests improved access to social and economic development and education for girls and women, with better access to high quality obstetric care. It also recommends education of society regarding fistula occurrence and management, as well as family counselling to help these affected women receive the support they need.

**Waiting for attention and care: birthing accounts of women in rural Tanzania who developed obstetric fistula as an outcome of labour**

Lilian T Mselle, Thecla W Kohi, Abu Mvungi, Bjørg Evjen-Olsen and Karen Marie Moland


This mixed method study of birth experiences by women who subsequently developed fistulae was designed to identify barriers to accessing adequate care during labour and delivery and was conducted between October 2008 and February 2010. To the authors’ knowledge at the time of writing, such a study had never before been carried out in Tanzania.

This was mainly a qualitative study, based on 16 interviews with women suffering from obstetric fistulae at the Comprehensive Community Based Rehabilitation in Tanzania (CCBRT) disability hospital in Dar es Salaam, but with a quantitative component taking the form of 151 questionnaires completed by patients with fistulae from both CCBRT and Bugando Medical Centre in Mwanza.

Broadly, the authors describe four categories of delay in obstructed labour: deciding where to give birth, struggling to reach a health facility, waiting at the health facility and receiving unskilled care.

When deciding where to give birth, almost all women had wanted to give birth in a health facility, but for only 7% was the eventual decision left to them. The husband or mother-in-law had the final say in around 60% of cases, and mostly chose home births, for reasons such as convenience, custom and cost. Lack of decision-making power, distance to a health facility and income poverty led many women to labour at home. The family commonly called upon traditional birth attendants (TBAs), with one woman reporting ‘in our village, there is a TBA, she is the one who harmed us’. With the decision-making power often lying with the husband, a woman had to wait after the onset of labour for him to return (frequently from farming) to decide how to proceed.

It took two or more days to reach the final place of delivery for 51% of the women, with the authors suggesting lack of trust in the healthcare system or birthing culture as the reason for this. Public transport was the means of transport for 43% of the women and 20% walked or were carried. One woman with no transport described: ‘I had very strong labour pains and after about two hours walk, I felt like something had ruptured in the womb. I started bleeding and we had to stop and rest before I could continue walking.’

The women interviewed perceived that the substandard care in the health facilities arose from negligence by healthcare providers. Many lacked support during the birth process; often being left to push alone. One woman had her mouth covered by one nurse, while others applied fundal pressure to her abdomen.

The authors describe poor monitoring and referral routines following consistent reports that the women were left for many hours or even days before the decision to refer them to a higher-level facility was made. One woman pushed for 48 hours at a dispensary before a doctor attended and delivered the head, and then, unable to deliver the body, transferred her to a hospital.

Overall, the delays resulted in 85% of the births being stillbirths. The authors conclude that delays in receiving adequate care after arrival at health facilities were the most central finding in the women’s accounts. Until this is improved, lack of trust in professional care will continue to cause delays prior to arrival in the health facility. The authors recommend governmental strengthening of existing health services, making them ‘available, accessible, acceptable and of adequate quality’ for rural Tanzanian women.
Preventing and treating fistula

They all knew about grief, the loss of much-wanted children and the shame and loneliness that comes to those with fistulae.

The problem of obstetric fistulae: a personal view

Mr Michael Bishop FRCS

Michael Bishop is a retired consultant urologist. He has had a long career working in fistula care in Uganda, Sudan and Nepal. In this article he gives an overview of the problem of obstetric fistulae.

Obstetric fistulae are caused mainly by ischaemia (restriction of blood supply) of adjacent pelvic organs resulting from obstructed labour from the delay in the provision of facilities for operative delivery. Other contributing factors in developing countries include: harmful cultural influences, poverty, ignorance, illiteracy and the low value of women in society. Specifically, when labour does not progress, traditional birth attendants may waste critical time, even if it is recognised that western style facilities are required. Transport may be poor or non-existent and the health centre to which the woman is taken may have no resident medical staff or equipment. This in turn reflects on such issues as emigration of medical staff, corruption and maladministration.

Unfortunately there is a major problem of confidence in data provided from official sources on maternal mortality and obstetric fistulae in particular. The process from data collection to analysis is flawed. This is hardly surprising in countries where comprehensive registration of births and deaths is non-existent. Even if a determined effort is made to document various aspects of maternal health in a defined segment of the population, this can be disrupted by political turmoil and war; both of which are likely to lead to escalation in incidence of maternal death and fistulae. At a local level, the accuracy of data collection is also likely to be limited by reluctance among women to admit to the problem, which for many is a cause for shame and exclusion from society.

Invariably, official government estimates of incidence and prevalence of fistulae underestimate the problem. A more accurate impression may come when a local population becomes aware of a facility offering successful fistula repair and the service is broadcast by local media supported by community education programmes originating in the health facility. This is particularly well exemplified where a new service is established, for example, in Nepal.

Fistula surgery is plagued by problems of classification and assessment of outcome. Several systems are available for grading of the fistula according to the likelihood of success with closure and a reasonable functional result in the hands of a competent surgeon. The relatively poor prognostic implication of involvement of the urethra and closure mechanism is acknowledged but they are difficult to use and the objective classification of a fistula often needs to be qualified by additional description.

Outcome is particularly difficult to assess in a population of patients who are often nomadic or live far away from the fistula centre. Often the surgeon will have returned home before the catheter is removed. Ideally, just before this is done, a dye test should be performed to assure at least early evidence of closure of the fistula hole but this is by no means the rule in every unit. Until recently, closure tended to be the marker of success in fistula surgery. However, perhaps with increasing involvement of urologists and urogynaecologists, there is growing recognition that stress incontinence is a common problem leading to a poor outcome. Other consequences of the ischaemic process may also have been underestimated: necrosis of the bladder wall will be self-evident but more subtle functional changes caused by loss of detrusor compliance and injury to parasympathetic innervation may be more difficult to detect. For obvious reasons there are few data available on the long-term symptomatic results of fistula repair and fewer still of objective outcomes in terms of even simple urodynamic assessment. Surgical success in terms of closure of the fistula have been achieved in up to 91% of cases of mixed complexity, with up to 25% having significant incontinence of urine. The majority had genuine stress incontinence but a proportion had detrusor overactivity and presumably the majority of this group had poor compliance. More surprisingly perhaps, a significant proportion of those with detrusor overactivity, either isolated or mixed with stress incontinence, responded to anticholinergic therapy.

It must be acknowledged that there is a delayed failure rate or, in other words, loss of continence despite the fact that the patient may have left hospital with good urinary control. This may be in part due to increasing stress incontinence but also to late breakdown of the repair. No doubt a multiplicity of factors is involved extending from vaginal trauma from early sexual activity to overfilling of the bladder despite advice to the patient to void regularly within the confines of a small-capacity bladder. Sadly, subsequent ill-advised attempted vaginal delivery, which may again be prolonged, can lead to breakdown of a vulnerable repair.

The longer a fistula unit is established, the greater the likelihood that simpler fistulae will be treated in peripheral hospitals in the network.
by surgeons with less experience or confidence, but ability to recognise a fistula beyond their capabilities and to refer the patient to the central unit. Increasingly, the work of the base hospital will concentrate on the more difficult cases requiring multiple attempts at repair; operations for stress incontinence and urethral reconstruction. These generally have less satisfactory outcomes. The treatment of stress incontinence is discussed further in another article but it hardly needs emphasising that there is little comparison between treating sphincter weakness in Europe and the USA where it is largely due to extrinsic causes and attempting to correct loss of function in a short, rigid tube, which is the end result of urethral damage and repair in the setting of obstetric fistulae.

The specialist hospital will also have to focus on the ‘terminal’ patient who remains severely incontinent after multiple attempts at fistula closure and/or unsuccessful stress incontinence surgery. She can either be discharged as an emotional, physical and psychological wreck and arguably in a worse situation than when she first entered the system, or urinary diversion can be considered. The issue is extremely controversial. It is very questionable whether an ileal conduit should ever be performed where long-term stomal problems need to be managed and appliances provided on a regular basis. On the other hand, a modified ureterosigmoid diversion has been shown to be very effective in providing a satisfactory functional result, at least in the short term. A counter argument has been that there will ultimately be a high risk of development of colonic tumours but more seriously perhaps, there is little opportunity to monitor the patient for serum electrolyte abnormalities and progressive chronic metabolic acidosis.

Finally, fistula surgery should be no exception to the principle of recognising the need for continuing audit and research with due consideration for the application of and discussion of ethical issues. It should surely be self-evident that a surgeon from the developed world should operate to the same rigorous standards in a developing country even though his or her work will be less likely subject to critical scrutiny than back home. The International Society of Fistula Surgeons can set standards, encourage membership and submission of research papers, unify practice and coordinate the work of the multitude of organisations involved in fistula care.

Vesicovaginal fistulae in Nepal
Dr Shirley Heywood FRCOG Gynaecologist, NGO International Nepal Fellowship, Nepal

Shirley Heywood is a gynaecologist working for the NGO International Nepal Fellowship in the rural west of Nepal and describes the fistula treatment service that she runs in the region.

Nepal is a beautiful country but with difficult terrain, a largely rural population, a recent history of civil war and an unstable political situation all contributing to hinder development of health, education and communication facilities, which are less than adequate particularly in the western half of the country.

Until very recently, obstetric fistula was not officially recognised as a public health problem in Nepal. Since 2011 the United Nations Population Fund has coordinated a campaign with government health services and fistula treatment centres. There are still no firm facts about the numbers of women with fistulae but a team performing an obstetric fistula needs-assessment estimated a prevalence of 4000–5000, with an incidence of 200–400 annually. There are facilities for fistula surgery in Patan (Central Region) and Dharan (Eastern Region) but no hospitals providing surgical treatment for women with fistulae in the western half of Nepal. Patan hospital, with 13 gynaecologists, has been treating fistulae since 1987 but up until 2010 only 443 women with fistulae have undergone surgery. BP Koirala Institute of Health Sciences has 13 gynaecologists, two of whom perform fistula surgery. It held its first fistula camp in 2008 with support from Gynécologie Sans Frontières.

Since 2009 the International Nepal Fellowship Surkhet Programme has run fistula repair camps in mid-west Nepal.

Our first two camps were very small. The Mid West Regional Hospital in Surkhet has only 50 beds so to expand we needed to find more accommodation. In March 2011 the International Nepal Fellowship (INF) marquee, home of many INF conferences, was erected in the grounds of the Mid West Regional Hospital. For six weeks the tent was a place of peace, hope and healing. The 68 women who gathered were from 21 different districts, from the mountains and the plains, young and old, from different ethnic groups, speaking different languages, but sharing a common suffering. They all knew about grief, the loss of much-wanted children and the shame and loneliness that comes to those with fistulae.
If health workers understand the importance of what they do in preventive health, what may often seem routine and uninspiring work becomes life-saving.

Educating health workers about fistulae

Marquee in the grounds of Mid West Regional Hospital, Surkhet

Inside the marquee

In 2012 the marquee was needed again and in 11 days we operated on 31 patients. A camp does not provide the best conditions for fistula surgery and we hope for a permanent centre in the future.

INF has been running an outreach programme since 2010. In 2011 we planned a large camp with a target of 50 patients. Most patients live in isolation because of their shame and we needed to find them. We have treated over 80 women through the camps, aged from eight to 75 years, with between two months and 40 years of history of incontinence. Surgery for obstetric fistulae is important and can change lives but it is the second best option. Prevention is better. The outreach programme trains auxiliary nurse midwives and mother and child health workers from rural health posts. They are the immediate supervisors of the grass roots workers in the villages who are likely to know of women with fistulae.

They are also the people whose work is vital if we are to stop fistulae occurring. The majority of health workers at health post level do not know what an obstetric fistula is or how it is caused and would not recognise a patient with a fistula if she presented to them. They do not know that there is treatment.

Using drama, true-life stories and photos depicting everyday activities such as shopping in the bazaar, attending a wedding and drinking tea with friends, we tell of the suffering, isolation and shame of a woman with a fistula. We want to convince these health workers that this is a condition that needs to be eradicated. We teach about how a fistula is caused, the symptoms and prevention. Teaching on how to avoid obstructed labour starts at the beginning of life with the importance of good childhood nutrition and avoidance of early marriage and pregnancy. Family planning and good antenatal care with counselling on birth preparedness; supervised delivery by skilled birth attendants and timely referral when labour is not progressing normally; use of prophylactic catheterisation, when a macerated baby is delivered after a long labour all lie within the skills and responsibility of the health post workers.

Pauri (pictured right) was catheterised for six weeks after delivery because three days in labour led to a ruptured uterus and obstetric fistula. The fistula healed spontaneously.

If health workers understand the importance of what they do in preventive health, what may often seem routine and uninspiring work becomes life-saving. We will never know how many women’s lives are saved or fistulae are prevented because a health worker takes the time to help their clients plan for a safe delivery.
It is sobering to remember that this long-term suffering could have been easily prevented if the woman had been able to get to a hospital for a timely and safe delivery.

The problem of continuing urinary incontinence after obstetric fistula surgery

Mr Andrew Browning MRCOG, Director of the Selian Fistula Project in Arusha, Tanzania

Obstetric fistula surgery presents many challenges. It is one thing to be able to close the defect and try to restore normal anatomy, but it is quite another thing altogether to obtain a functional closure, ensuring normal continence. There are varied reports about the extent of incontinence after fistula surgery, from 8% to more widely accepted figures of 18–33%, even up to 47% in an unpublished survey performed in the Addis Ababa Fistula Hospital in 2003. As with all things, it depends on how closely you look for the problem. In the early work by Kelly and Kwast, the figure was the number of women returning to the hospital with continuing incontinence despite a closed fistula. It is likely that many women would have remained at home with mild incontinence. The figures of 18–33% had a standard way of looking for incontinence including a basic set of structured questions ranging from ‘are you wet with cough or heavy activity?’ to ‘are you leaking urine involuntarily when lying?’ A cough examination with a full bladder was used to confirm the diagnosis.

The exact nature of the incontinence is often complex and only a handful of studies have investigated the nature of the pathology. One study of 22 women with severe incontinence following fistula closure underwent urodynamic assessment: 41% had genuine stress incontinence (GSI); 14% had GSI and poor compliance; 41% had GSI and detrusor overactivity, and 4% had voiding disorder and overflow incontinence.

The prognostic factors associated with incontinence after fistula surgery have been shown in observational studies and include:

- If the urethra is involved in the defect; the strongest determining risk factor with an odds ratio of 8.4. The urethra is involved in some way in up to 63% of cases (unpublished series, Browning, Barhirdar, Ethiopia).
- If there is significant vaginal scarring, such that a small Sims speculum cannot be inserted into the vagina without relaxing incisions.
- The larger the fistula.
- If there is a reduced bladder volume, more so if less than 100ml.

During the first operation, at the time of fistula repair, a simple method can be used to try and reduce the rate of continuing incontinence after repair. For all urethral fistulae larger than 4mm, a sling of pubococcygeal muscle (or scar tissue if the sling had been destroyed by the long labour) placed beneath the urethra can reduce the incontinence rate in these women from 33% to 18%. This has been shown in a retrospective analysis but has yet to be proven prospectively.

Continuing incontinence after surgery poses an enormous problem for the woman. If the continuing incontinence is severe, such that the woman is still leaking when walking and lying, she will have difficulty re Integrating into her normal life, will suffer depression and will think that not much was actually achieved during the operation.

The cure rate from this operation is around 70% and largely maintained at six months’ follow-up. Longer-term follow-up is not yet available. The remaining 30% of women would be evenly divided to 15% improved severity of incontinence and 15% no change in incontinence. Most of these women would be dry when using the urethral plug and with this be able to live a relatively normal life.

The women still suffering with continuing incontinence after fistula repair also pose a long-term management problem. Most of these women are still young, in their twenties, and they face another 30 or 40 years, maybe longer, with this problem and might be dependent on a device such as a urethral plug for all this time. Later in life there is undoubtedly a potential for recurrence of incontinence making further management more troublesome. It is sobering to remember that this long-term suffering could have been easily prevented if the woman had been able to get to a hospital for a timely and safe delivery.
Obstetric fistula should be a rarity, but that requires a skilled cadre of birth attendant.

The Hospital by the River

Mr Jeremy Wright FRCOG

Jeremy Wright retired from NHS practice in Surrey, UK, in 2011 and worked as a volunteer Obstetrician & Gynaecologist with Maternity Worldwide (UK) in Gimbi West Wollega before taking up his appointment as specialist fistula surgeon and gynaecologist at Hamlin Fistula Hospital, Ethiopia.

Hamlin Fistula Hospital, the ‘Hospital by the River’, quietly opened its doors to hundreds of women awaiting treatment for obstetric fistulae in 1975. The Derg or Red Terror was just starting and many businesses and institutions were being nationalised, so it was important to remain under the radar. Word spread and the hospital was always full, with many women camping at the gate, awaiting treatment. The hospital was, and still is, entirely supported by charitable donations, the only place in Ethiopia where treatment is completely free.

The hospital was the brain child of Reg and Catherine Hamlin who arrived in Ethiopia to teach and practice midwifery in 1959, but soon developed a passionate interest in obstetric fistulae. They initially treated women in the various hospitals in which they worked but soon realised that specialist care was needed. It took 15 years to raise enough money to build the Hamlin Fistula Hospital. Reg died in 1993 and Catherine continued his work. Now having celebrated her ninetieth birthday, she still takes the steep walk from her house to the ward, to both talk to the women and offer treatment advice based on her enormous experience.

There is now not one Hamlin Hospital but six, with five in remote parts of the country, all built on the same pattern. They consist of airy clean wards surrounded by beautiful gardens, where women sit, talk and recover from the surgery and the appalling psychological traumas of the condition. There is also now a midwifery school taking students from local communities and training them to recognise the signs of obstructed labour so that appropriate referral can be made and treatment offered. Women labour and deliver at home far from any help, so an important function of these midwives is to explain to the women, and importantly their family, the need to seek help. Travel is difficult and expensive and the families may be reluctant to allow this, hoping for a normal outcome as ‘labour is normal,’ though delays may be catastrophic. There is also now a nascent ambulance service so transport is possible.

In a country with rudimentary medical records and with much of the population living in isolated rural communities it is difficult to accurately assess the prevalence of obstetric fistulae, probably 0.2 per thousand, but certainly the numbers being treated are falling. A significant number are postmenopausal and have lived isolated lives, shunned by the population until they hear that treatment might be possible. Due to the social stigma and poor infrastructure, patient identification remains a problem, women live with the injury not aware that help is available.

The classic obstetric fistula is low, involving the urethra and bladder base. There may also be significant loss of vaginal epithelium. Although it is usually possible to close the defect, loss of bladder volume leads to frequency and the urethral damage to dribbling or stress incontinence. For many the associated vaginal scarring will lead to aparenia, divorce and childlessness. Thus the social problems are endless. From a surgical point of view the spate of recent articles on neo-vaginoplasty could offer real hope for these women with the use of silicon vaginal molds and buccal mucosal grafts. It is early days in the development of these new procedures and their suitability and reliability in the local context has yet to be demonstrated but it is certainly worth investigating, with adequate training and resources.
The nature of fistulae is also changing with about a quarter of all new fistulae seen at the Hamlin hospital being iatrogenic, high juxta-cervical or utero-vesical fistulae following Caesarean section. This is usually in multiparous women in obstructed labour with a malpresentation at full dilatation for some hours or in whom the uterus has already ruptured. This is not surprising as Ethiopia is a country with 20 million women of child bearing age and about 400 obstetricians, the majority of whom live and work in the capital, Addis Ababa. Caesarean section in the rural areas is carried out by heath officers, who have a para-medical training and nine months surgical experience or by newly qualified doctors with minimal surgical experience, seconded to rural areas. Unsurprisingly ureteric injuries are quite common too, re-implantation with a Boari flap leading to significant reduction in bladder capacity. However as the urethral sphincter is usually intact, long-term continence is likely.

For those in whom the destruction is so great that reconstruction is impossible, diversion may be possible, either an ileal conduit, or a sigmoid pouch, but the difficulties of looking after these in a rural community without basic sanitation or supplies of bags are often too much and many prefer to remain incontinent. There is also major social stigma for these women who will become outcasts in their community. In the past many have been employed in the hospital working as a health care assistant adding to the high quality of care due to their empathy with the patients. Others have resided in the purpose built rehabilitation centre. Today patients receive extensive counseling prior to surgery and if they are suitable for surgery individualised patient plans are prepared to find the most appropriate community setting where the patient can be reintegrated whilst continuing to receive any medical support and stoma management required from the hospital.

Whilst we manage to close many of the fistulae, just over half our patients will achieve full continence immediately following surgery. If they become pregnant they are encouraged to return when they will be offered a Caesarean section to protect the repair, an occasion celebrated throughout the hospital by much ululation and joy. These are the lucky ones, for the others the outlook is varying degrees of incontinence, which may be improved by remedial surgery, physiotherapy and lifestyle change. For many of them their condition can be managed and a reasonable quality of life can be achieved. For some however the outlook is less positive. The basic principles of fistula surgery have largely remained unchanged since Reg and Catherine Hamlin started their pioneering surgery nearly 60 years ago. Changes in suture technology and surgical approach have improved closure rates and patient outcomes and now modern techniques of tissue grafting offer real hope to those women with vaginal scarring and vesical tissue loss. Ultimately though, obstetric fistulae should be a rarity, but that requires a skilled cadre of birth attendants, capable of diagnosing and managing obstructed labour, and if Caesarean section is required, facilities for this to be safely carried out by appropriately trained and skilled personnel. Until this is achieved in Ethiopia or any other country the skills and dedication of hospitals like the Hamlin will still be needed.
Kitovu Health Care Complex is situated in rural southern Uganda, in the Masaka region.

Under the leadership of Sister Dr Maura Lynch, a retired surgeon, the hospital is run by the Congregation of the Bannabikra (Daughters of Mary) Sisters of Uganda. It has become particularly well-known for its outstanding fistula care services. Women from remote areas all over Uganda and further afield, from Rwanda, Kenya and Tanzania have benefitted from the free, life-changing service Kitovu provides.

Here we show how Kitovu has developed over the years and how the RCOG is helping to develop its fistula services even further.

Kitovu Hospital

1993

Kitovu started offering fistula services to women with the support of international voluntary doctors, many of whom are Fellows and Members of the RCOG.

2004

As the fistula service grew, Kitovu started to train local doctors in some fistula surgery, receiving special recognition from the Ugandan Ministry of Health as the first training centre of its kind in Uganda. One year later, the hospital proudly opened the St Annes Obstetric Fistula Unit.

Sister Maura Lynch

Dr Maura Lynch is an inspirational woman, a wonderful surgeon and through her fistula work has trained hundreds of fistula surgeons and cured many fistula patients. Maura has FRCS and is also an Honorary Fellow of the East African College of Surgeons, having practised as a surgeon in Africa for over 50 years.

Her dedication to women’s health started early in her career when at the age of 16 upon leaving school she became a member of an International Missionary Congregation on Professional Women whose principle aim was to increase health and welfare of women and children, particularly those who had been marginalised. After pursuing her training in medicine Dr Lynch was assigned to Kitovu Mission Hospital where she was also responsible for training. Her work here has developed and runs four camps per year, where she provides free care to women with obstetric fistula, treating a total of 450 patients each year. In 1999 she cofounded the Association of Surgeons of Uganda and in 2006 she was awarded Fellowship of this Association in recognition of her work in the clinical field and her contribution to training.

In 2013, in recognition of her work, she was awarded Honorary Fellowship of the Royal College of Obstetricians and Gynaecologists.

The founding of Kitovu Hospital

The hospital was founded almost 60 years ago when Arch Bishop Joseph Kiwankya invited missionaries from Ireland to build a small medical facility in Masaka. From small beginnings, the hospital has grown into a large over 200-bed complex, offering curative and preventative care to patients from far and wide.

Kitovu puts a strong emphasis on holistic care particularly for poor women and children. As such, many have stayed in contact with the hospital to work or to spread the word of the work that they do.

Kitovu’s fistula camps

Four times a year, Kitovu hosts a fistula camp. Visiting surgeons from around the world come voluntarily to provide fistula repair services. Women come from the most remote areas all over Uganda to undergo life-changing operations.

In March 2013 I had the opportunity to take part in a Fistula Camp at Kitovu Hospital. I tried to prepare myself for the trip by reading about neglected obstructed labour and its association with obstetric fistula but it was hard to imagine how devastating childbirth injuries really could be.

On arrival we unloaded and immediately went down to the fistula ward to meet the many women who had come from all across Uganda.

The tireless and dedicated nursing staff had already done most of the work and it was left to the visiting surgeons to assess the women and their fistulae to plan the operating for the camp.

Over the two weeks the operating was intriguing, showing the spectrum of how easy some fistulae can be to repair and how difficult others are. The whole camp was set up with such care and attention and all the women seemed to bond over their experience. This bond on one hand shows us the great strength of these women but on the other revealed a bond that is formed out of tragedy and despair and should not need to exist.

The post-operative hope of each woman was palpable as they carefully tended to their catheters hoping that when it is removed their lives may start to rebuild again.

Dr Ed MacLaren MRCOG

RCOG Global Health Trainees Group
September 2013

The RCOG, with the kind assistance of the Ugandan Maternal and Newborn Hub, undertook a ‘Story-gathering’ trip to Uganda. During this visit, Professor Alison Fianer and a team from the RCOG and Mide 91, a bespoke story gathering team, went to Kitovu. Professor Fianer, who has worked at the Fistula Clinic at CCBRT Tanzania, was impressed with the excellent facilities and care offered to the women and it seemed that with so much already in place, the RCOG could help Kitovu develop from four camps to a continuous fistula service, in order to treat more women and save them waiting for visits from international surgeons.

January 2014

After sharing this project idea with Johnson & Johnson, they offered to provide the RCOG with a ‘Gift in Kind’ by way of funding for High 5+, a group of top level MBA students from the UCLA Business School to visit Kitovu and investigate how it might develop a business plan to move into a full-time fistula service provider. Over a six month period they met with local Ministry of Health officials, UNFPA, Mulago based fistula surgeons, Dr Maura Lynch and the management team at Kitovu. They visited Ethiopia, Kenya, Tanzania and India as part of their research. They reported their findings in Singapore in May 2014. The RCOG is now working with Kitovu to help develop their service to expand the number of women treated for fistula from 235 to 1300 per year over a 3 year period.

We aim to do this by supporting Kitovu to increase services through local, national and international partnerships; the training and retention of Ugandan fistula surgeons, midwife and nursing staff; community sensitization and public health education on the causes, prevention and treatment of fistula and through a strategic outreach approach to eventually develop a centre of excellence in Uganda for fistula work.

October 2014

As part of our project with Kitovu, the RCOG has teamed up with FIGO (The International Federation of Gynecology and Obstetrics) who agreed to accept Dr Florence Nalubega, an obstetrician and gynaecologist based at Kitovu, on their six week fistula training course in November 2014. She will be travelling to the Hamlin Fistula Hospital, Addis Ababa, Ethiopia for the training. Sr Dr Nalubega has completed her MMEDs and taken part in four fistula camps at Kitovu. She would now like to expand on her knowledge and expertise to be able to undertake higher level fistula surgeries. Dr Nalubega leaves Kitovu for six weeks in November to start this first step towards her training.

To ensure that the service at Kitovu does not suffer in her absence, the RCOG has arranged for a volunteer consultant obstetrician and gynaecologist from Northern Ireland to cover her work. This will enable the RCOG to understand how service delivery is carried out and work with the Kitovu team to help shape the project over the next few years. We will be sending more volunteers from the UK to aid with the project as it progresses.

Mr Marcus Filshie
FRCOG

Through his generous donation to the RCOG, we are able to send volunteers from the UK to aid with the development of teaching and training local staff. Mr Filshie himself worked in Kampala in early 1972 but had to escape after eight months as the brutality of Idi Amin’s dictatorship took hold. The experience had a profound effect upon his future development which is why he has decided to help the RCOG in sending volunteers to Kitovu:

‘It was an enormous experience for me...I was told that the College had a serious interest in supporting a number of initiatives in Uganda. This was an amazing coincidence as it gave me the opportunity to support the College in a project which I had wanted to do for some time...The decision to work in Uganda is daunting. Having made that decision so many years ago, I can honestly say it was a magnificent experience.’

The RCOG/Marcus Filshie Fellowship will send volunteers over the next three years to develop Kitovu’s training and educational programmes both at the hospital and through outreach work.

Our first Global Health Fellow – Dr Sandra McNeill
FRCOG

Dr Sandra McNeill graduated from Queens University Belfast in 1989, entering into O&G training after two years travelling and working in Queensland, Australia. She completed her training as a flexible trainee and has now been a substantive NHS consultant for 10 years, with a special interest in urogynaecology.

Sandra is currently Deputy Head of School and Training Programme Director for the Northern Ireland Deanery having had a long interest in medical education.

Sandra explains: ‘Many years ago I saw a television programme about the Addis Ababa Fistula Hospital and felt that this was an area that I would love to be able to contribute to. The Marcus Figshie Fellowship will provide a great opportunity for me to experience O&G in a less developed part of the world whilst allowing a local doctor to train in fistula surgery. It should be a very rewarding experience for both of us.’

Sandra is starting her placement at Kitovu in late October 2014 shadowing the work of Dr Florence Nalubega. She will take over Sister Florence’s work once she leaves for the Hamlin to undertake fistula training.

The future

The Kitovu/RCOG partnership will bring lasting, sustainable development in fistula care service and help many more women who are living with the trauma of fistula. If you are interested in supporting our project, through volunteering, mentoring, taking part in our Challenge Events or donating yourself, please get in touch with us.

globalhealthinfo@rcog.org.uk

Follow us on Twitter @RCOObstGyn
Changing attitudes and improving access to care

Tulip Mazumdar, Global Health Reporter, BBC News

In a rural central Ugandan village, 17-year-old Sulaina sits on the mud floor of the tiny home she shares with her mother and younger brother and sister. She wants to help provide for her family. But she can’t. She can barely leave her house. Wherever she goes, a sickly smell follows her. That’s because she is constantly leaking urine. The rags she has stuffed in her underwear are drenched quickly, and then the urine starts running down her legs. She has sores all over her thighs where the urine has burned her.

She developed a fistula after giving birth to a baby girl last year. Like so many women in rural parts of the country, she left it too late to get to hospital. ‘I was in labour for two days, then on the third day I went to a clinic and gave birth there. I had a baby girl,’ she said. ‘She died before I got to see her. I never even held her in my arms.’

Sulaina says she believes a neighbour cursed her and that’s why her baby died and why she now has a hole in her bladder. ‘My baby survived for two days but she had something pulling her away. When it left her the curse caught me. I felt as though black ants and termites were biting me. I would not be in this condition now if they hadn’t bewitched me.’

‘Many people in such rural areas believe in witchcraft over medical science’ says Dr Florence Nalubega, a gynaecologist at Kitovu Hospital in Masaka. Today she has teamed up with local popular radio DJs in the centre of Lwanaggwa village to talk about family planning and the importance of getting pregnant women to hospital to give birth rather than relying on traditional birthing attendants in the community. She says these older women in the community have little or no medical training and don’t know what to do when things go wrong. But many women trust them over doctors. ‘Some people here have told me that we in the hospital actually cause fistulas by using catheters which we put in the bladder,’ says Dr Nalubega.

‘They also use their own local plants like leaves from mango trees: they dry the leaves and then mix them with watered-down clay. They then drink it because they think it softens the (pelvic) bones and allows an easier birth.’

It’s these sorts of attitudes and beliefs health workers are trying to change. The other major obstacle for women giving birth safely and avoiding complications is money. Getting to the nearest hospital can take hours and is expensive. Plus there is the cost of treatment on arrival. That’s why a traditional birth attendant and herbal remedies, rather than expensive medicines, can seem like the better option.

Around 7,200 women die during or soon after childbirth in Uganda every year according the United Nations Population Fund. The organisation’s representative in Uganda, Fundira Esperance said: ‘For every maternal death, six to 15 mothers survive with chronic debilitating ill health such as obstetric fistula.’ ‘The face of fistula is represented by women who live in rural areas, are not educated and are within the lowest wealth quintile.’ The organisation started an ‘End Fistula Campaign’ in 2003 with the goal of making obstetric fistula as rare in developing countries as it is in the developed world. But the surgery to repair fistula is complex and expensive. At around $700 it’s completely out of the reach of those who need it.

At Kitovu Hospital in Masaka, doctors from Chelsea and Westminster Hospital in London fly in for two weeks four times a year to provide free repair surgery for as many women as they can treat in that time period. It is paid for by the hospital’s health charity Borne, which raises funds to pay for the treatment, hospital stay and transport costs for patients. The doctors also train Ugandan medics to carry out the surgery. The hope is they will eventually be able to take over.

Mr Shane Duffy FRCOG is a consultant obstetrician and gynaecologist at Chelsea and Westminster Hospital and is carrying out Sulaina’s surgery. He has been heading the training and fistula repair camp at Kitovu Hospital for eight years. ‘It’s quite a specialised operation,’ he says. ‘It’s a difficult operation and needs good equipment and good personnel to be able to support the surgeons. ‘We have a local surgeon here at Kitovu who is able to do the simple fistulas, so she is starting to take them on.’

Uganda’s health minister Ruhakana Rugunda says the government has a number of schemes providing free fistula treatment, but
admits there is a long way to go to ensure this totally avoidable and treatable condition becomes a thing of the past. ‘The prevalence of fistula is a reflection of the healthcare standards but also the economic status of the population. As we gradually improve services of care and the economy picks up, people can access health services more easily, then the incidence of fistula will come down.’

After two hours in theatre, Sulaina returns from surgery. The 4cm hole in her bladder has been repaired. From today she will no longer have to walk around in a constant state of shame. Her mother sits at her bedside stroking her hair. ‘I am hopeful her future will be better now,’ she says. ‘She was in such a bad way, but I have hope all will be well.’

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Update on the FIGO/RCOG and Partners Competency-based Fistula Training Programme

Sohier Elniel
Consultant Urogynaecologist, University College London Hospitals NHS Foundation Trust, London

Obstetric fistulae present a major health problem in Africa and Asia. Access to effective and safe obstetric care, including Caesarean sections, is often limited in these countries. Furthermore, long distances combined with the high cost of care and poor nutrition make women more vulnerable to obstetric fistulae, particularly in West Africa, the horn of Africa and the Indian subcontinent. There is still tremendous disparity between risks associated with pregnancy and labour faced by women in the developing world compared with women from wealthier nations.

In the last six years, two significant unifying worldwide initiatives have contributed significantly to this field.

The first initiative was developed by The International Federation of Gynecology and Obstetrics (FIGO), an international multidisciplinary body of obstetricians and gynaecologists, and the Royal College of Obstetricians and Gynaecologists (RCOG) as well as the United Nations Population Fund, Engender Health and the Pan African Urological Surgeons Association. The partners published a competency-based training manual on urogenital fistulae, sustained as a consequence of obstetric trauma. The aim of the manual was to provide standardised and competency-based training in fistula surgery. The training structure is modular; each module or subject area is further subcategorised into specific objectives. Each module can be achieved within a stipulated period of time, as determined by the trainer and the trainee. Using the agreed information provided by fistula surgeons, the manual was created similarly to the RCOG training programme for general obstetrics and gynaecology with learning tools, logbooks and objective structured assessments of technical skill for each module. This was the first time that such an initiative had been developed for a specific internationally recognised health condition. In addition, the manual also provides guidance in audit and research, thus promoting publication in medical and nursing literature.

The second initiative involved the formation of the International Society of Obstetric Fistula Surgeons (ISOFS) in Ethiopia, www.isofs.org. ISOFS are holding their 5th annual conference in Kampala at the end of October 2014. Those surgeons who are already working within a dedicated institution are protected to some degree, but those who work in isolation need local, national and international support. By agreeing to form a body of experts in the field, the society has already overcome a huge barrier – acceptance of each other’s expertise and position.

The main objective of ISOFS was to unify surgeons from all over the world in adopting the same strategy in classification, training and education. It has become the ‘voice’ of fistula surgeons.

Current status
Since the manual was published, there has been a significant uptake by many trainers in the field. All trainers underwent training, run by the FIGO team and local faculty members. The first ‘training the trainers’ course took place in Dar es Salaam, Tanzania in August 2011. All participants, being well-established fistula surgeons within their own right, found the training sessions very helpful in understanding how the manual should be used. Since then, training courses have been run at Hoggy Hospital with Professor Gueye in Dakar, Senegal (July 2012); in Nairobi, Kenya (April 2013); at the Addis Ababa Fistula Hospital in Ethiopia (August 2013) and in Lagos, Nigeria (December 2013) with Professor Ojengbede. Over fifty trainers have been trained so far.
There is still tremendous disparity between risks associated with pregnancy and labour faced by women in the developing world and women from wealthier nations.

As the programme has become implemented within each country, trainees have been increasingly selected by their national professional urology or obstetrics and gynaecology organisations or by their Ministry of Health to undertake the programme.

The training period
The training period is individually tailored following a discussion between the trainee and trainer: Assessing the trainee’s ability and original competency helps determine how soon a trainee can be signed off at standard, advanced or expert level of competency. It is anticipated that most trainees will need at least six to eight weeks of training to achieve a standard level of competency.

As of May 2014, eight fistula surgeons have been accredited with standard or advanced competency in fistula surgery and 11 new fistula surgeons have achieved standard level of competency in fistula surgery. The trainees came from different countries including Togo, Niger, Senegal, Nigeria, Madagascar and Nepal. A new call for applicants was launched in July 2014 by FIGO.

Mentoring and Evaluation
The programme has increased capacity in fistula surgery in under-resourced settings. This increased capacity also means an increased need for the trainees to improve their local surgical facilities to accommodate their newly acquired skills. Mentoring of trainees at their local site is also important to ensure they maintain and develop their skills, and thus a mentoring and evaluation programme has been established to run concurrently with the training programme. Data on the number of patients looked after by the newly-trained surgeons is being collected on a quarterly basis, and visits to the training centres have been conducted to ensure that governance and standards, according to the principles of the programme, are maintained.

Accreditation and certification
The accreditation and certification process for completion of each level of competency is shared between FIGO and the professional societies. As the numbers of trainees increase, it is planned that each country’s designated professional body along with its academic institutions will provide the competency-based fistula surgery training programme as a specialised form of postgraduate education. They will then become the certification body. This will require negotiation between academic institutions, professional bodies, Ministries of Health and FIGO with their partners.
The issues which are at the basis of it, social and economic development of ‘at risk’ girls/women must be on the agenda. Fistula should be on the human rights agenda for women and girls.

Funding of the training programme

The funding of trainees accepted onto the programme, which covers travel expenses and accommodation, has been provided by a mixture of agencies working closely with and guided by FIGO. This includes the Fistula Foundation, WAHA International, Engender Health, the United Nations Population Fund, Johnson and Johnson, and several others.

In the future, it is anticipated that governments and institutions will take over funding of the training programme, when they become part of the established postgraduate education system.

In the last few years many positive changes have taken place in helping women with fistula access care. Raising awareness of obstetric fistulae was the starting point in helping deliver this care. As a community we have finally been able to move forward.

The tremendous efforts of the surgeons in the past have brought obstetric fistulae to the forefront of the world’s medical media. This exciting work has meant that more women were being treated, more dedicated units were being developed, more doctors were being trained and most importantly, more lives were being rebuilt. Without the dedicated teams of doctors, nurses, physiotherapists, occupational health therapists, social workers, cured and non-cured patients working as health auxiliaries, non-government organisations and philanthropists, none of this would have been fully realised.

It must not be forgotten that this condition is completely preventable. The issues which are the basis of it, social and economic development of ‘at risk’ girls/women, must be on the agenda for them to be tackled. Furthermore, it should be on the human rights agenda for women and girls.

Until there is universal access to emergency obstetric services, antenatal healthcare services, improved transport and socio-economic status, improving medical care for these women will be a challenge. A holistic approach to medical and surgical treatment, rehabilitation and follow-up in the community is a step in the right direction. We anticipate that in time this training programme will improve outcomes for the women. However, it has to be part of a wider picture, incorporating integrated social, economic and cultural development programmes. There is no doubt that in the long term, socio-economic development will be more cost-effective and sustainable than medical treatment. But until then, we must rely on the dedication and delivery of good care by all the professionals working in this field.

The FIGO and partners competency-based training programme goes some way in contributing to this commendable objective.

Changing women’s lives: Preventing and treating fistula

Denis Robson
Recent Director – African Affairs, Johnson & Johnson

In collaboration with partners in the five priority countries (Cote d’Ivoire, Liberia, Tanzania, Kenya and Ethiopia), Johnson & Johnson is investing in proven programs and pioneering groundbreaking models to reduce the impact of fistula. Our partners, including community-based organisations, non-government organisations and UN agencies are working in unique and innovative ways to:

• prevent fistula through quality obstetric care
• increase access to fistula repair surgery
• help women with fistula reintegrate into their communities and regain control of their lives.

Making Progress to Improve Health & Save Lives

Preventing Fistula through Quality Obstetric Care

The best way to prevent fistula is to ensure that expectant mothers have access to quality health care services before and during childbirth. Through a partnership with the Royal College of Obstetricians and Gynaecologists and Liverpool School of Tropical Medicine, Johnson & Johnson has supported a three-day training program that addresses five major obstetric complications, including obstructed labour, which cause fistula. The program is designed for midwives and physicians who provide obstetric care, to enable them to identify and manage emergency birth complications. The program trained over 200 health care providers in Nigeria to better serve their communities.

Increasing Access to Fistula Repair Surgery

Johnson & Johnson partners with organisations such as FIGO, United Nations Population Fund (UNFPA), Fistula Foundation, Comprehensive Community Based Rehabilitation in Tanzania (CCBRT), Direct Relief International, Women and Health Alliance (WAHA) and the Addis Ababa Fistula Hospital to help women access obstetric fistula surgery services and train more surgeons. These partnerships help underserved women living with fistula in countries including: Cote d’Ivoire, Liberia, Tanzania, Kenya and Ethiopia.

Reintegrating into Communities: Global Campaign to End Fistula

Fistula treatment goes far beyond repairing the hole in a woman’s tissue. Many patients – especially those who have lived with the
Using mobile phone technology to transfer funds represents an innovative means to overcoming a significant barrier to healthcare access for patients in developing countries.

condition for years – require emotional, economic and social support to fully recover from their ordeal. Through the Global Campaign to End Fistula led by UNFPA, women receive counseling as well as life and job skills training to help them get back on their feet after surgery. Working with communities is also pivotal to reduce stigma surrounding the condition and ensure women are welcomed back into society.

Denis has recently retired from J&J after more than 40 years of service. Ian Walker, Managing Director MISSA and Director Corporate Contributions, Conrad Person give an overview of his contribution to the development work of Johnson & Johnson.

Denis built a strong foundation for the Ethicon business in the Middle East, spending four years based in Iran as Regional Manager followed by six years commuting to Africa. In 1997 as General Manager, he led the start up of Johnson & Johnson Professional Export an umbrella company serving all MD&D franchises in 44 countries recording continuous business growth for 11 years. More recently, Denis transitioned in 2008 to Corporate Contributions where he was appointed to his current position as Director, African Affairs. In this role he applied his knowledge and extensive professional relationships to create Health Workforce Development programmes that resulted in enduring capacity for surgical, nursing, and midwifery training. Literally millions of Africans now find maternity care and surgical treatment more readily available because of his work. He retires leaving a legacy of passionate leadership for improved healthcare in sub-Saharan Africa and many friends for Johnson & Johnson.

‘TransportMYpatient’

Alison Fiander
Formerly Technical Advisor to CCBRT’s VVF service

Tom Vanneste
Formerly Deputy Disability Hospital Director, Dar es Salaam, now studying for an MBA at London Business School, UK.

People with disabilities are among the poorest and most vulnerable in the world. Even when health care is provided free, transport costs may pose an insurmountable barrier to accessing treatment. In this report Alison Fiander and Tom Vanneste outline an initiative in Tanzania that uses mobile phone technology to transfer funds covering transport costs for patients with obstetric fistulae.

The Tanzania Fistula Survey found that many girls and women with fistulae must travel more than 500km to reach one of the major centres for fistula repair, with some travelling as far as 1000km. Many respondents in the survey commented that the cost of fistula treatment and transport makes it difficult for girls and women to receive care.

The Comprehensive Community Based Rehabilitation in Tanzania (CCBRT) Disability Hospital initiative ‘transportMYpatient’ was set up at the end of 2009 in order to tackle this barrier of transport costs. Prompted by an article in The Economist which highlighted the increasingly varied uses of mobile technology, CCBRT introduced the scheme to harness the potential of mobile money to cover transport costs. So far the focus has been on women with obstetric fistulae and patients with cleft lip and/or cleft palate.

The initiative was supported by the United Nations Population Fund with a grant to build the ‘ambassador’ network; pay transport and treatment costs for women with fistulae, and to convert an existing building into hostel lodgings for women with fistulae awaiting surgery. Ambassadors are doctors, nurses, other healthcare workers and non-governmental organisation staff living in the community all over Tanzania, who are aware of the services offered by CCBRT. The network was established in early 2010 through a CCBRT outreach team who searched for appropriate individuals to serve as case finders/ambassadors.

How the ‘transportMYpatient’ initiative works

An ambassador identifies a patient in need of treatment and contacts CCBRT about the potential referral. The referral is screened by a CCBRT doctor to ensure that, as far as is possible, the patient’s symptoms are compatible with an obstetric fistula or cleft lip/palate.

Arrangements are then made to pay for the transport costs to bring the patient to CCBRT’s Disability Hospital in Dar es Salaam. Through a text message (SMS) from a CCBRT phone to the phone of the ambassador, the required transport funds are transferred. This transfer currently takes place through Vodacom’s M-PESA technology (M-PESA; M standing for mobile and PESA meaning money in Kiswahili). The ambassador collects the cash at the nearest M-PESA agent (there are over 6000 M-PESA agents in Tanzania), buys the bus ticket and puts the patient on to the bus. In order to cover their own costs of going to the M-PESA agent and dealing with the logistics of the bus ticket, ambassadors receive an incentive of TSH 10 000 (£5/$6) for each patient that successfully arrives at CCBRT with the correct and required transport receipts. The original 2010 target was to transport 60 patients to CCBRT via the ‘transportMYpatient’ initiative.
Results of the transport initiative

In 2010, a total of 239 patients came to CCBRT via the transportMYpatient initiative and were operated on as shown in Figure 1; comprising 129 women with obstetric fistulae and 110 patients with cleft lip and/or palate, representing four times more patients than the original target set for 2010.

![CCBRT Disability Hospital in Dar es Salaam](image)

Figure 1. Number of patients with vesicovaginal obstetric fistulae or cleft lip and/or palate referred to CCBRT during 2010 via the transportMYpatient initiative.

Through the ‘transportMYpatient’ scheme, CCBRT increased the number of fistula operations carried out in 2010 by 65% compared with 2009. During 2011 166 women with obstetric fistulae came to CCBRT via the transportMYpatient scheme, representing a 29% increase compared with 2010 and the total number of fistula repairs increased again as shown in Figure 2.

One of the strengths of the transportMYpatient is efficiency and responsiveness. Within a few minutes of receiving a request for transport money, a transfer to the ambassador is completed and the ambassador is able to collect the money from an M-PESA agent and buy a bus ticket for the patient.

CCBRT is looking at methods to expand the ambassador network to locate more hard-to-reach individuals living with treatable disability such as obstetric fistulae. The possibility of using traditional birth attendants, community elders and community meetings to spread the word is also being investigated. Expansion of the ambassador network addresses lack of knowledge that medical treatment exists for these disabilities as well as overcoming the financial constraints. Many patients live in rural villages without access to the media, some are illiterate and some may need to hear the message that treatment exists more than once before deciding to access the services. CCBRT is also investigating the possibility of asking successfully treated patients to be ambassadors and find others living with obstetric fistulae. At the start of 2012 CCBRT had 144 ambassadors spread over all the regions in Tanzania. However, the density of ambassadors is low in some regions and this requires addressing.

![Graph](image)

Figure 2. Total number of fistula repair operations carried out per year at CCBRT’s Disability Hospital, 2005–2011, indicating launch and impact of transportMYpatient initiative.

The transportMYpatient initiative surpassed the initial targets set in 2010 and continued to see an increase (29%) in obstetric fistula referrals using the scheme in 2011. To support the ambassador network an ambassador conference was held in 2011 and early 2012 at CCBRT to update participants on progress of the transportMYpatient initiative with interactive sessions on how to find patients with treatable disability including obstetric fistulae, along with a hospital tour.

Using mobile phone technology to transfer funds represents an innovative means to overcoming a significant barrier to healthcare access for patients in developing countries.
Beyond fistula

Moving beyond incontinence

Julia Irani
Project Coordinator at Mwanza Intervention Trials Unit (MITU), Tanzania

Julia Irani was formerly a Master’s student in International Health at the University of Bergen’s Centre for International Health in Norway. As part of her Master’s thesis, she conducted a qualitative study on the experiences during reintegration of women treated for obstetric fistulae in Tanzania. The study was carried out in collaboration with Women’s Dignity, Comprehensive Community Based Rehabilitation in Tanzania and Muhimbili University of Health and Allied Sciences with assistance from several hospitals in Tanzania. In-depth interviews were conducted with a total of 36 women who had undergone fistula treatment at least six months previously. This was done at women’s homes in rural settings across three regions: Dodoma, Mwanza and Mbeya. A focus group discussion with these women was also conducted in Singida. In this article, Julia narrates the stories of a few women to convey some of the findings from her study. (NB All names have been changed for confidentiality.)

Reintegration of patients with fistulae deals with a very selective group of women. These are frequently poor women, both young and old. Women who survived childbirth, Women who, more often than not, bore the loss of a child. Women who suffered from incontinence. Women who heard about treatment. Women who found themselves at a hospital that could repair fistulae. Women who returned home, after treatment. In some ways, you can think of them as the fortunate ones.

The question is how long did they have to wait before getting treatment? We interviewed Grace 10 months after she was treated. Grace got married around 16 years of age. She got pregnant but miscarried because her husband came home drunk one day and started beating her. She lost her daughter. Not long afterwards, she conceived again and went to her mother’s house for delivery. ‘When labour pain started, I was afraid they would think I was lying, so I did not disclose … on the second day, I told my mother’ and that was when she was taken to the hospital. She delivered her second daughter; but she had died as well. When she returned home with a fistula, her husband abandoned her. She moved in with her mother. Some years later, her parents died. We asked her who she lived with now, and she said ’I live alone and my God is the second one’. She explained that she did not go to church because of fear of leaking. We asked her if she ever considered remarrying and she said ‘I ask who wants to marry a woman leaking urine?’ More than 55 years passed before she was finally treated for the fistula. She is now about 75 years old. When we asked her how she felt after treatment, she said ‘I felt ok … I rested for one day only … but on the second and third day I saw urine leaking’. She did not want to get treated again; she said it was not as bad as before, she now only leaks slightly when she is asleep. To make ends meet, Grace collects rocks, carries them home and breaks them into smaller pebbles, fills these into a sack, and sells it to construction workers for approximately 30 pence/sack whenever there is a demand for it. Mostly, she is dependent on her sister’s grandchildren to provide her with food.

Eva had a different story. We interviewed Eva 14 months after she was treated for a fistula. She suffered a fistula after her first pregnancy at the age of 18. She started labour in the dispensary and on the third day she was taken to the hospital, where she delivered a dead baby. She noticed she was leaking, and so a catheter was inserted and she was sent home. She stayed with the catheter for 2 months, before she was referred to a hospital for fistula repair. She is completely cured, and is now 6 months pregnant. She said she was happy with her husband and hoped to have ten children.

The experience during reintegration is influenced by the time and success of treatment. About one-third of the women we interviewed said they were not completely dry after treatment. They either still had a fistula or some stress incontinence. Successful reintegration, however, goes beyond the physical condition of incontinence. Societal factors and support networks play an important role as well.

When Flora returned home after treatment, her mother-in-law put pressure on her to sleep with her husband. She refused and returned to her mother. When we asked her about remarrying, she said ‘if a man approaches me, I will refuse. I will tell him that I don’t want to be destroyed any more’. Flora’s mother helped her through the process of acquiring treatment, because of which they are now left poorer than before. She said ‘The cultivation season passed, my mother did not cultivate, so currently we do not have food, we are buying food’.
She added ‘I dream to have money then my mind can settle’. Another respondent, Stella, who is now cured and has a supportive husband, talked about their plans before her fistula. ‘… After selling this harvest, some would be for food and with the remaining we wanted to buy iron sheets (for the roof of their house) … but when I got the problem, that money was used to send me to witchdoctor … that witchdoctor required a lot of money … one goat and 20 000 shillings (€8)’. They were now struggling to recover the assets lost in acquiring health care.

For a woman in Tanzania, the ability to bear a child is tightly connected with self-worth. The women who already had children often did not want more, but those who did not really felt the loss. When we asked Gloria, who had gone through three marriages with a fistula and several miscarriages, what pained her the most, she said ‘only having no child. It hurts me so much. If I had a child, I would not feel the pain as much’. She added ‘I am not worried about becoming pregnant even if I get fistula, provided I have a child, I will not care’. Some women conceived children even with fistulae, some of whom were outside of wedlock.

Fistulae impact the physical, social, economical and psychological life of women in Tanzania and all these aspects need to be accounted for when assessing successful reintegration. It is also important to realise how difficult it is to carry out home follow-up visits for these women. There were days when we drove on unpaved, bumpy roads for eight hours, searching for one woman. Some villages were not accessible by car and we had to hike for hours. Understanding the environmental context that these women come from gives perspective on the inaccessibility to emergency obstetric care and why the women that we interviewed are, in fact, the fortunate ones. Awareness is increasing and women are getting treatment sooner. I believe there is hope, a hope to move beyond incontinence.
Obituary:
Mr John Kelly FRCS FRCOG OBE

Mairead Kelly and Mr Shane Duffy FRCOG

Mr Duffy worked extensively with Mr Kelly at Kitou Hospital in Uganda in fistula repair surgery and training of local doctors. We are grateful to Shane and to Mairead for their permission to publish the following obituary.

Consultant obstetrician and gynaecologist (b 1931; q Glasgow 1956; FRCS, FRCOG, OBE, Hon MD), died from idiopathic pulmonary fibrosis on 2 August 2013.

John Kelly became a world authority on obstetric fistula, having spent 45 years operating on thousands of women in the poorest parts of Africa and Asia. He set out to save these marginalised women from the indignity of fistula and the horrifying consequences of this condition.

Having qualified from Glasgow University in 1956, Kelly learned his trade of obstetrics and gynaecology at the London Hospital in Whitechapel. He then took up a consultant and senior lecturer position in Birmingham, where he met his wife, Christine. It was on a sabbatical in Nigeria in 1967, while the Biafran war raged, that Kelly first observed the devastating and preventable condition of obstetric fistula. It helped change his life. He met women who had been ostracised by their husbands and communities because of incontinence after obstructed labour; some had been driven to the point of suicide.

In 1969 he returned to Africa, joining a pioneering husband and wife team in Ethiopia: Reginald and Catherine Hamlin. They had founded the Addis Ababa Fistula Hospital and were overwhelmed by the sheer scale of what turned out to be a silent epidemic. Kelly continued to help there every year during his annual leave, sometimes working in terrible conditions. He was way ahead of his time: then the developed world paid far less attention to the problems of women’s health in the poorest areas than, thankfully, is the case now.

Kelly took on the challenge of working in some of the world’s remotest areas, as well as war zones. Arriving in a rural hospital in Angola in 2006, having travelled for days on a dirt track, he found an operating room where the lights didn’t work, and there was no table appropriate for fistula procedures. The local carpenter was brought in to make one, but the stirrups broke during the first operation. Notwithstanding, Kelly persevered and completed all the cases. He was treated for dysentery when he got home. The local team were surprised to see him return the next year. That very unit is now the national fistula centre for Angola.

After retirement from the NHS in 1996, Kelly began to spend seven to nine months each year on this work, without pay. He continued into his 80s, and it was only the devastating consequences of idiopathic pulmonary fibrosis that eventually stopped him. He paid his last visit, to Uganda and Ethiopia, only 15 months before he died.

His legacy to the developing world is fistula treatment programmes in some thirteen countries in Africa and South Asia. He operated on more than 12,000 fistula patients, and trained many local surgeons. He was well known for taking on complex cases, which others would not attempt, and achieved an extremely high success rate. He often extended his trips, unable to say no to women who needed his help. For this service to impoverished and outcast women throughout the world, Kelly was made an Officer of the Order of the British Empire in 2005 and awarded an honorary doctorate by the University of Birmingham in 2007. He hated the spotlight and would always say that he was only one part of a team—acknowledging the contribution and dedication of the cleaners, laboratory workers, and others who give so much.

Kelly said in an interview shortly before his death that he was looking forward to the day when the door would be opened to admit women for their fistula treatment and there would be no one waiting. There are few who have done more to achieve this than Kelly himself.
The RCOG/Marcus Filshie Fellowship

Kitovu Hospital, Uganda

Harriet Nabatte suffered the devastating loss of her first child and then developed an obstetric fistula:

‘I went to the clinic in the village to have a baby but I pushed for about nine hours. My baby died. After I went back home the urine started dropping and dropping. I didn’t feel that I have to go for urinate, but the urine just dropped out. I spent my time all day pardoning myself.’

‘I carried on going to my job as a teacher but I would have reached a time where I couldn’t have carried on because I was kept having to pardon myself to pad myself and it became sore. My husband was very patient about it. He was trying to comfort me during that problem and he was the one who brought me here for my operation but I worried that if I couldn’t get this operation, I could lose my job and my husband.’

Maternal mortality is a desperate blight on sub-Saharan Africa.

In this region, the lifetime risk of maternal death is 1 in 40, for developed nations it is only 1 in 3,800. This is a major cause of health inequality, also impacting significantly on the life chances of surviving children.

For every woman that dies, 20-30 women are left with significant disability including the devastating condition of obstetric fistula.

Kitovu Hospital

Kitovu Hospital is a Catholic mission hospital situated in the Masaka region of southern Uganda, roughly 130km south of Kampala. Under the leadership of retired surgeon and Honorary Fellow of the RCOG, Dr Maura Lynch, the hospital hosts four fistula camps per year, led by Mr Shane Duffy FRCOG who also led the first emergency newborn and obstetric care course at Kitovu in March 2014.

Through a generous donation by Mr Marcus Filshie FRCOG, the RCOG is helping Kitovu to develop a year-round fistula service to women.

Through a donation from FIGO, a Ugandan doctor from Kitovu will be leaving the hospital in Nov/Dec 2014 to train in fistula surgery at the Addis Ababa Fistula Hospital in Ethiopia.

How RCOG Global Health Fellows will help

A Global Health Fellow will cover the doctor’s departure to Ethiopia for a short-term Fellowship from Oct 2014.

In addition, we have a commitment to Kitovu over the next 3 years and so we aim to send Global Health Fellows for longer-term placements to help develop the centre to a full time fistula service provider.

Our Global Health Fellows will be required to support the delivery of high quality maternal care and timely emergency obstetric care to aid fistula prevention as well as conduct data collection in order to develop research around post-fistula complications and support the development of local staff capacity at Kitovu. Global Health Fellows will also have the opportunity to participate in Kitovu’s fistula camps and maternal care courses.

If you are interested in becoming involved please email globalhealthinfo@rcog.org.uk
Have you read the RCOG Global Health Strategy 2013-17?

Learn about the global health focus for the RCOG
Visit www.rcog.org.uk/globalhealthstrategy