

# Fistula Needs Assessment Report

## Introduction

Obstetric fistula, which includes both vesico-vaginal (VVF) and recto-vaginal fistula (RVF)\*, represents a critically important and largely neglected issue in the field of reproductive health. The World Health Organization (WHO) estimates that at least two million girls and women currently live with fistula and that an additional 50,000 to 100,000 are affected each year.<sup>1</sup> For the vast majority of these girls and women, services to repair their condition remain unattainable for a number of reasons: their lack of knowledge that such a condition can be repaired; the distance they must travel to reach a facility that provides treatment; the low likelihood that, even if they can get to a facility, it will offer fistula repair in its portfolio of services; their inability to pay for the services if they are available; and the backlog with which facilities that do provide repairs are faced.

The clinical component of fistula care presents a number of difficulties, yet the context in which facilities are based and the degree to which communities are equipped to reintegrate women once repaired may also prove to be obstacles to treatment. The social rehabilitation of women after a successful fistula repair is challenging, as these clients are often extremely poor, abandoned by their husbands or partners and without skills to earn a living on their own. These conditions may render them especially vulnerable once they return to a community.

## Background on Obstetric Fistula

In general, in low resource settings, fistulas are caused by obstructed labour. During this time, the baby's head remains pressed against vaginal and bladder wall tissue for a prolonged period of

time, causing necrosis and, ultimately, a fistula to develop.<sup>2</sup> While some women also develop fistulas following a hysterectomy or C-section, the majority of women in the countries where the needs assessment took place appear to have them at a young age, most often in conjunction with their first vaginal delivery.<sup>3</sup>

In the nine countries visited, the underlying causes are likely to include malnutrition (and possibly repeated infections) leading to small stature which, when combined with pregnancy at a young age, results in pronounced cephalo-pelvic disproportion. In addition, insufficient access to emergency obstetric care, coupled with the desire to deliver babies at home (which often occurs without skilled attendance) results in a situation where women, especially young women, are at high risk. In addition to these well known causes, physicians in the region also report fistulas resulting from poorly managed C-sections and deliveries within health facilities.<sup>4</sup>

Exact prevalence rates in the region (and, indeed, the world) are not known, but Dr. Tom Raassen and Dr. Festus Ilako extrapolate a figure of 6,000 to 15,000 new fistulas occurring each year in East Africa. This figure is based on the knowledge that every year, three million women survive deliveries in the region; for each thousand of these surviving mothers, there are an estimated two to five cases of fistula.<sup>5</sup> If approximately 1,000 repairs are performed each year in the region, at least 80 per cent of women with fistula are not getting services.

Applying the same calculation to all the countries visited would mask significant differences between them and might paint an overly general picture of a condition affected by everything from health care infrastructure to cultural atti-

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\* It should be noted that VVF in this report is used to refer to all varieties of fistula that result in urinary incontinence. Up to 85 per cent of the fistulas in this category will be vesico-vaginal, but others may be urethro-vaginal or due to stress incontinence. RVF refers to fistulas that result in stool incontinence, although a few will stem from third-degree tears to the perineum.

tudes to labour. However, given that the circumstances that lead to fistula are widespread in each nation, it is safe to assume that many women in these countries are living with fistula and that the vast majority of them are not able to seek repair services.

### **Needs Assessment**

To begin to grasp how best to address the range of possible strategic interventions, it is important to understand what facilities exist, how they operate and whether they are well situated to improve and/or expand their services. This needs assessment is intended to provide a snapshot of how some clinical services for fistula clients have been organized. It does not include survey data nor does it necessarily cover every facility in each country offering services. Rather, it is a glimpse of the issue, as seen through the eyes of the clients who seek services, the health service infrastructure that supports services and the professional staff who provide surgical repairs and care for the women as they recover from surgery.

Importantly, the data gathered by the individuals who conducted the research are primarily qualitative and represent one moment in time. These data were gathered via a series of rapid needs assessments during a six month period.

While additional data have been shared from some locations since the research took place, this supplemental information is not included in this report, as the information within it is considered timebound. The intention was to create a picture of the situation in various locations in order to flag issues for further investigation.

### **Methodology**

The needs assessment was conducted by one clinical and one programme staff member from EngenderHealth during a series of site visits between May and October 2002. In each country, two to 12 public sector (usually district level) and private sector (usually mission) hospitals were visited. Administrators and professional staff (physicians, nurses and midwives) were interviewed, as well as fistula clients whenever possible. The fistula clients interviewed included those who a) were awaiting repair surgery; b) were immediately post-surgery and were recovering in the post-operative ward; c) were significantly (> 6 months) post-surgery and d) had carried a pregnancy post-surgery and delivered by C-section.

In addition, each country visit included meetings with representatives from the Ministry of Health (MOH) and local policy makers, as well as UNFPA (United Nations Population Fund) country offices, which all have an interest in supporting fistula work.

A simple, nine-question survey instrument (see appendix for sample) was used for each interview. Clinical facilities were toured and the wards, waiting areas and operating theatres were observed whenever possible. When it was feasible to review theatre logbooks, team members took advantage of the opportunity.

### **Country-Specific Findings**

The following is an analysis and summary of findings at a country level, followed by fact sheets on each site visit.