

UGANDA

Background

Reproductive health in Uganda is characterized by a **total fertility rate of 7.10, a contraceptive prevalence rate of 18 per cent for modern methods and a maternal mortality ratio of about 1,100 per hundred thousand live births**, according to UNFPA's *State of World Population 2002* report. More than 60 per cent of women deliver at home. Of the remaining percentage who deliver in a facility, many are insufficiently attended and end up suffering morbidity, such as fistula, as a result.³¹

The **Ugandan MOH has initiated a process to decentralize and upgrade health centres** at the subdistrict level, with a focus on increasing access to emergency obstetric care. The emphasis is on three fronts: training doctors and motivating them to live and work in remote areas; equipping and maintaining operating theatres; and securing emergency transport services.

Five years ago, in a pilot project in three districts, UNFPA supported **additional training of TBAs to help them understand signs of complications in labour**. UNFPA supplied two-way radios so that providers could initiate communication with the closest health unit. They also donated transportation in the form of small Suzuki jeeps. The result proved that the maternal mortality ratio could be improved, so UNFPA has initiated support to an additional 14 districts.³²

The Uganda Health Sector Strategic Plan for the period 2000 to 2005 **sets optimistic national targets for reproductive health, including an increase in contraceptive prevalence to 30 per cent, a decrease in maternal mortality to 354 per 100,000 live births and an increase in deliveries attended by skilled health workers from almost 40 per cent (in 1995) to 50 per cent**.³³ To achieve these goals, the MOH recognizes the need for public and private health sector service delivery organizations to work in partnership as well as the need to refurbish the health outposts that are understaffed and under-resourced. In

addition, the MOH is concerned with motivating doctors to remain in remote locations to build community confidence in the health services available.

Issues and Challenges

The needs assessment team visited four service delivery sites in the country where fistula repairs are offered: Kitovu Mission Hospital in Masaka, Kamuli Mission Hospital in Busoga, Lira District Hospital in Lira and Nsambya Mission Hospital in Kampala. In addition, the team met with representatives of the UNFPA country office, faculty from Makerere University and Mulago Hospital and the director of clinical services at the MOH.

The interviews, observations and discussions painted a picture that was remarkably similar across the country and was characterized by a **great and growing number of women with fistulas, a short supply of physicians with the skills to repair them, operating theatres that were few in number and insufficiently equipped and tremendous reliance on the work of visiting, volunteer doctors** from other countries who visit for periods of a week to a month once or twice a year to help stem the tide of women waiting for repairs.

The women themselves tend to be young (15 to 20) and to develop fistula during an obstructed labour with their first pregnancy, which almost invariably results in a stillbirth. In some cases, the woman's husband or partner has left her and she has **no means to get to a service delivery site or to pay for the services that she needs**. Although women were able to receive surgery even when unable to pay, user fees were in place in each of the locations, except the government hospital. The cost in the private, mission hospitals ranged from the equivalent of \$75 to \$120 USD per repair, depending on the interventions and length of stay required. As one nursing sister commented in Kamuli, "More and more, women just can't pay and we understand why they sneak away once they are

healed....” The issue of clients needing to pay was often cited as a reason more women don’t come and “...are just off suffering in the bush,” according to a physician at Lira Hospital.

In the absence of collecting user fees, staff members note that **service delivery organizations are having a harder and harder time supporting fistula repairs**. When clients are being operated on, other surgeries must be put on hold. Since fistula clients need to spend a somewhat longer period of time recuperating in the hospital than many other types of clients, they also prevent other (potentially paying) clients from using the beds they occupy. Furthermore, although they are expected to furnish basic surgical supplies, they usually cannot and often bring an attendant who may also need assistance securing basic supplies like food and accommodation.

Although **HIV/AIDS** is recognized as an important issue, and certainly the issue which is garnering the most resources for service delivery sites, it is **not well integrated into the care of fistula clients**. Every site visited had a well-funded HIV/AIDS programme that included both community outreach and VCT, but fistula clients were not given any special counselling on the issue. One nursing sister at Nsambya explained that if a fistula client were to receive special counselling on HIV/AIDS, it would worry her, as she would be suspicious about why she was singled out to receive this information. “She would say, ‘Why are they telling me this? What have they seen inside me when they opened me up for surgery?’” explained the nurse. In fact, in two cases, the number of days for VCT had been reduced from twice to once a week due to lack of demand, yet AIDS is known to be prevalent.

In the mission hospitals, the **HIV/AIDS programme is the only part of the facility where clients can get any kind of family planning**—in this case, condoms. Otherwise, they are referred to local government-supported clinics where they can obtain a variety of family planning methods. No sites had any tracking mechanisms in place to determine how many of the women did actually go

to the referral sites to seek family planning, although some sites did have women return to the same facility for a C-section to give birth when they next became pregnant, as they had been asked to. **There is a widely held perception among staff that family planning is not a critical need for fistula clients**. Yet staff readily recognize that if clients do return to their homes, they will likely be returning to the conditions that put them at risk in the first place: a remote location, health facilities that are difficult to get to and poor economic standards. Obviously, the woman’s pelvis would not have changed size, so she would be at even greater risk if she were to get pregnant again and, even with good access to a C-section, should probably not, for her own health, have many pregnancies.

The **doctors who attend to the women with fistulas are a dedicated but small group**. They perform the fistula repair surgery when they visit once or twice a year, except at Nsambya, where three consulting gynaecologists and the medical superintendent are able to perform operations on a regular basis as needed. The visiting doctors are revered and their work is much appreciated, especially when they have been able to successfully repair a fistula that had previously been deemed inoperable or had been unsuccessfully operated on. The visiting doctors are, in one case, on staff with the African Medical and Research Foundation (AMREF) and, in the other two cases, are retired surgeons from the United Kingdom who travel to Uganda on a volunteer basis to assist with fistula repair and training.

Because their visits are relatively infrequent, there are inevitably far more women to be operated on than one surgeon can possibly attend to. The result is that women must return to the queue the next time the doctors can visit. In addition, because the doctors are trying to operate as quickly as they possibly can, they are not in an ideal situation to train other providers, as the process of teaching and training requires time that is in short supply. Ideally, visiting doctors would be able to stay for slightly longer periods of time to build teaching into their responsibilities.

For this reason, the **need for local doctors to be trained** is paramount. Many of the specialists (most of whom are OB/GYNs) who are interested in receiving training are aware that training could be obtained in Ethiopia or Nigeria, but are also well aware of the waiting list for a training slot in these locations. They know as well that they will need to secure funding to get trained if they have the opportunity to do so. One senior physician explained that, while there is interest locally in being trained, the reality is that doctors are eager for a number of different kinds of experiences to increase their range of skills and ultimately their earning power. Fistula clients are not likely ever to be in a position where they can pay much, unlike, for example, a hysterectomy client or someone seeking services for infertility.

In addition, there is another factor which prevents some doctors from seeking training in fistula repair: **the perceived high rates of failure for fistula surgeries**. The providers interviewed for this assessment mentioned success rates of 70 per cent to 90 per cent for first attempts. It is likely, however, that others perceive success rates to be lower than this range. Alluding to the difficult nature of fistula repair and the fact that there is not always success, one physician explained that the district level health unit is starting to understand that, unlike family planning and nutrition where a small input can have dramatically positive results, “fistula is just the opposite.” The input is big (and complicated) and the outcome may be failure.

Finally, **a strong cultural value placed on giving birth at home** is pervasive and often leads to women arriving at facilities when they are in desperate situations with obstructed labour and fistulas have already formed. As one doctor explained, “It is sort of as if you are not a real woman unless you can push a baby out on your own.” This desire to deliver at home, often without skilled attendance, is complicated by several factors. She may be attended by a TBA, some of whom have a vested financial interest in not referring her to a health facility, even if her labour is complicated. In addition, many women feel they

need their husband’s permission to seek health care, so would wait until he arrived home before trying to seek help. Given the need to find transport or secure funding for it, the delays can be extensive. Once in a facility, there may be additional delays or insufficient skills to manage the labour successfully. One doctor noted that 10 per cent to 15 per cent of the fistulas he currently sees occurred in the facility, some in relation to poorly managed labours and C-sections.

Recommendations and Critical Needs

- **Capitalize on antenatal care being well attended and use visits as a chance to highlight prevention of fistula.**

Even in the most remote locations, women are seeking antenatal care once or twice before they “disappear” pre-labour. Their visits are undoubtedly based on convenience, most likely in relation to the availability of time and money for transportation and clinic fees. These antenatal care visits could be used to explain labour complications, including what fistula is, how it happens and how it can be prevented. In addition, some ideas about planning for a delivery in a health facility could be discussed as could certain signs of complications during labour and the need to seek emergency care quickly should these develop. Providers might also mention the need to begin to organize a transport plan early on in a pregnancy. These plans would include starting to put aside a little bit of money on a regular basis.

- **Integrate family planning and HIV/AIDS messages into the regular care of fistula clients, and make sure that clinics have adequate family planning supplies, including condoms.**

Although it is widely presumed at the sites visited that the majority of fistula clients are amenorrhoeic (not resuming menstruation after the trauma of the delivery which created the fistula, unless and until the fistula is repaired), a good proportion of the unrepaired fistula clients continued with regular menstrual cycles and even got pregnant again

in some cases. Given this scenario, it is critical that fistula clients be made aware of the dangers associated with getting pregnant again and be able to control their fertility as desired. They also are vulnerable to HIV, especially if they are in a situation where they need to find socio-economic stability without a partner. Anecdotal evidence from one site suggests that fistula clients sometimes have to resort to commercial sex work to provide for themselves and any children they have, a situation that may put them at an increased risk for undoing the repair as well as for contracting HIV. Mission hospitals appear to have acknowledged their responsibility to offer family planning services, but have not taken measures to address it beyond some attempts at mentioning referral sites.

- **Explore the feasibility of training interested medical officers to perform basic fistula repair.**

In the current scenario, medical officers are generally not considered suitable candidates for learning fistula repair, as they have not gone through any specialized training. If interested (and the team heard more than one example where this was the case), they may be able to learn how to perform simple repairs, a situation that could result in better pregnancy outcomes at the health outpost level. Medical officers are in far greater supply than specialists and may be more inclined to stay in a remote location, so if they were trained to handle obstetric emergencies and first and/or simple fistula repairs, women would have less need to travel to other facilities for basic care and be able to reach an appropriate facility more easily. A number of training options will undoubtedly need to be explored both for medical officers and for specialists who would potentially assist them with the more complicated cases. Such options include training pre-service for undergraduates, in-service for generalists, pre-service for post-graduates in surgery or gynaecology or in-service for specialists in surgery or gynaecology.

- **Conduct a needs assessment at a community**

- **level to better understand the lives of women who get fistulas, the social conditions in which they live and what might be done to ease their reintegration back into society.**

In every interview conducted, providers and administrators said they knew little about the circumstances of these women's lives and the process of reintegration they experience when they return to their community or go to other communities. The fistula clients who participated in this needs assessment had no access to any community services, so were forced to find their own way, relying on the help of family and friends. Not all clients have family and friends able or willing to help, however, so a greater understanding is needed about how communities might be mobilized to support these women.

- **Use findings from the needs assessment to conduct on-the-job training for nurses and social workers so that they may more adequately care for the women and help them to reintegrate once their fistulas have been repaired.**

In addition to the need for greater community awareness and support, findings from the needs assessment could also be used to inform some on-the-job training for nurses and social workers. Post-operative care, both within the hospital and following discharge from the hospital, is critical for fistula clients, not only for their physical recovery but also for their psychological health. With some basic training, hospital staff could be made aware of and trained to meet the special needs of fistula clients.

- **Explore ways to sustain local doctors' interest in fistula repair and make the services sustainable.**

Clearly, fistula repair is not easy or glamorous surgery and has a chance of failure that is higher than many physicians are comfortable with. It also usually involves clients who cannot pay. These reasons, together with insufficient equipment and low salaries for medical staff (who, therefore, may have an interest in seeing private clients part of the day), combine to put fistula repair at the bottom of the list of conditions for which physicians

might be interested in seeking special training. Special attention to providers and issues of motivation, perhaps in the form of a small research project, would help to shed light on what might make them interested in learning how to conduct fistula repair and maintain an interest in it. Putting some educational or economic incentives into place might also help sustain the commitment of local providers.

- **Consider creating a training centre for fistula repair within Nsambya Hospital.**

Since Nsambya Hospital is the only location where local doctors perform fistula repair on a regular basis, is centrally located, and has a relatively large caseload and a reputation for high quality services, it might make sense to consider establishing some kind of ongoing training for fistula repair there.

Fact Sheets for Uganda Site Visits

A. Kitovu Mission Hospital, Masaka, visited 6 May 2002

Size: 200 beds, plus an outpatient clinic and community-based health work primarily on HIV. Part of Medical Missionaries of Mary, Daughters of Mary network

Medical staff: Nine doctors and 150 nurses. They had an expatriate surgeon, Dr. Maura Lynch, doing VVF repair until recently; now, they rely on a visiting surgeon (Dr. Brian Hancock or Dr. John Kelly) to come twice a year for several weeks at a time.

Caseload: Fairly large. In September of last year, Dr. Kelly performed 54 repairs. Dr. Lynch had typically done about eight repairs a month before, but there were many others to do. There are many more VVFs than RVFs—approximately 90:10—but a few clients have had both.

Provenance of clients: Primarily the district, but some come from outside the district as well. Rakai has a large number of women with VVF, for example, but transportation is a big issue, so the hospital sent a vehicle to pick up some of the women and bring them back for surgery. Sometimes, the community health workers from the HIV project give clients funds to pay for transport.

Typical client profile: 15 to 20 years old, first pregnancy, accompanied by female family member or friend, very poor.

Assessment and screening process:

- Clients wait on benches in the corridor, which offers more privacy than the ward.
- Screened to determine whether they have obstetric fistula. The number and location of holes is also determined.
- Blood typing done.
- Haemoglobin measured.
- Pregnancy ruled out.
- Counselling given on surgery, the need for abstinence following surgery and the need to have a C-section if another pregnancy occurs. Two months worth of oral contraceptives is provided.

Post-operative care: Clients stay for a period of a couple of weeks to a couple of months. If surgery fails, clients wait three to six months for another attempt. If IVP is needed, clients are referred to a local hospital, but funds have to be raised to pay for this procedure, which costs about \$100 USD.

Rehabilitation/reintegration: There are no social services available to help clients get back on their feet and reintegrated into a community. Most do not go back to their husbands, many of whom rejected them originally. Women have to figure out a way to support themselves and find work. In communities where VVF is extremely common, such as one described in Rakai, there does not appear to be as much social stigma. In fact, when one doctor was doing a health talk in the community and described VVF in order to let the community know that repair surgery was going to be available at Kitovu, one person in the audience said, “But doesn’t that [VVF] always happen?”

Community outreach: Once the dates for a surgeon’s visit have been set, the doctors tell the community outreach workers, who discuss it in their health talks. An announcement on the radio is also made.

Perceived support at the policy level: Very little. Staff know that the last Minister of Health was interested because he came from a mountainous region where the condition was common; it is unclear how the current Minister will respond. It is very apparent to the staff, however, that the real money is in AIDS.

Estimated fully-loaded cost per procedure: \$75 USD.

Resources: Last year, the hospital received \$5,000 USD from a Tanzanian NGO; a small amount also came from the Irish Medical Association, where a website story resulted in a large individual donation. The Ugandan government provides support to the hospital, but not for VVF. The European Union gave a large five-year grant, which is in its last year. Hospital has a user fee policy which accounts

for 30–40 per cent of the overall budget, but VVF clients usually cannot pay.

Barriers:

- Funding.
- Dependence on volunteer, visiting doctors who bring their own equipment.
- Light (need a new one).
- Clients need funds for upkeep, food and accommodation while waiting for and recovering from surgery.
- If surgery is being done on VVFs for two to four weeks, then all other surgeries must be put on hold because the theatre is small. In addition, this makes the wards congested with clients who are not paying, so the situation amounts to a loss of revenue for the hospital.
- At a community level, education is needed on prevention and saving for labour and delivery, arranging transport, etc.
- Transport needed both for emergency obstetric complications and fistula repair.

B. Kamuli Hospital, Busoga, visited 7 May 2002

Size: 170 beds; surgical ward has 30 beds.

Medical staff: Four medical officers, 45 nurses and 13 nursing assistants. Visiting expatriate surgeon (Dr. Brian Hancock) visits twice a year for a week at a time, usually in April and November. In the early 1980s, a local doctor also did VVF repairs.

Caseload: In the beginning, it was difficult to get clients, but when Dr. Hancock said he would do them for free, many women appeared. During one week in April, he performed 14 repairs (four were still leaking afterwards) and in November he did 22 (all ended up dry).

Provenance of clients: Most come from the district, but some come from as far away as Busia (> 50 km) and close to Kampala (> 10 km).

Typical client profile: 20 to 30 years old, poor and have had VVF from one to 10 years. Most lost the baby, but one had VVF then five more children and

then got repaired. Last year, they had three clients in their 50s who had had hysterectomies. Women often come with a sister or aunt to help them and some bring their husbands and babies, too.

Assessment and screening process:

- Women come two to three days before surgery.
- Nurse screens for malaria and anaemia.
- Doctor screens for type of fistula and exact location.
- In addition, Dr. Hancock counsels clients on how the fistula happened, how big the hole is, how he plans to approach it surgically, the chances that it will be successful and the role of a catheter post-operatively.
- The need to have every other delivery by C-section is also emphasized.
- Clients are put on antibiotics right before surgery.

Post-operative care:

- Nurse talks about family planning; client is referred to the government-funded health centre in town (about one km away) if she wants a method.
- Clients stay in hospital for two weeks.
- Clients are counselled to abstain for six months.

Rehabilitation/reintegration: No community programmes are in place to help women get back on their feet. Women are often not able to pay and simply leave.

Community outreach: About a month before Dr. Hancock comes, announcements are made on the radio; these efforts bring in more women than can be operated on. Outreach workers go out into communities for immunizations and health education. Also, in the past, a doctor would go out to four different rural areas in the district to provide services on a regular basis, but the hospital lost its transport so can no longer perform this service. Women do come for antenatal care, however. A flat fee of 1,000 shillings (less than \$1 USD) entitles them to five visits, but most just come for three at a maximum and many just come towards the end of a pregnancy. A strong culture of delivering at home exists, so the ones who come to the hospital are normally already in dire situations with an obstructed labour.

Perceived support at the policy level: Staff are

unclear whether anyone at the ministry considers this a priority.

Estimated fully-loaded cost per procedure:

120,000 shillings (about \$75 to \$80 USD). A normal delivery costs 5,000 to 6,000 shillings and a C-section costs 20,000. Most women cannot pay, however, so there is a problem with people just leaving. Sometimes, they are asked to sign a paper saying that they will pay a little bit at a time, but they rarely do.

Resources: The Ugandan Government has paid a small amount to allow the hospital to lower their user fees; they have been able to lower their children's fees by 50 per cent (it is now 1,000 shillings for a child's visit) and adult fees by 25 per cent (now 2,000 shillings per visit). In addition to the church, government support and client fees are the only two sources of income.

Barriers:

- No local doctors are trained in repairs, but some of the medical officers are interested in learning how to do them.
- If a woman needs an IVP, she has to go to Kampala (Mulago or Nsambya).
- After two to three attempts, if a woman is still leaking, she is unwilling to try again and certainly would not pay again for an attempt.
- Funding is so uncertain that staff are given "allowances" rather than salaries because the salaries might stop at any time.
- Trying to collect user fees is very difficult.
- The theatre, facility and equipment are out of date and/or inadequate.
- Insufficient theatre space: when there is an emergency, the doctor has to stop the VVF surgery, attend to the emergency and then go back to the repair.
- Transport is a big issue.
- Follow-up is limited; some women come back to thank the doctor, but that is all.
- No community services are in place to help clients.
- Some are concerned that if local doctors are trained, they will not be able to pay out of pocket for surgeries for women the way the visiting doctor has, nor will they be able to provide equipment.

C. Lira District Hospital, Lira, visited 8 May 2002

Size: 282 beds; nine wards (some of them are quite small, five beds, for example).

Medical staff: 10 physicians, six medical officers, one dental surgeon, one ophthalmologist, one gynaecologist, one medical superintendent, 35 nursing officers, 80 regular nurses, 16 enrolled nurses, and 26 midwives. Nurses get on-the-job training for VVF. Visiting doctors include Dr. Brian Hancock, who had come five times, and Dr. Tom Raasse, who had come twice (at the time the team visited).

Caseload: Enormous. When the word got out that Dr. Hancock was coming, more than 200 women showed up; of these, all were registered, only about 50 were screened and another 20 operated on. The ones who are registered but not operated on are given priority for the doctor's next visit. Some are very difficult cases: the women may have already had unsuccessful attempted repairs. About 90 per cent of surgeries have been successful.

Provenance of clients: Most come from Lira and the surrounding area, but some come from neighbouring districts.

Typical client profile: Young women 16 to 20 years old, most of whom are accompanied by their sisters or mothers. They are very poor. For most, this is their first pregnancy, and most have lost their babies. After developing a fistula, many get "into a nasty relationship" with their partners and are abandoned by them and become social outcasts. Even friends give them a hard time. In general, women in the area do come for antenatal care visits, but more from urban than rural areas. In addition, providers noted that people handle the issue of AIDS very secretly.

Assessment and screening process:

- General exam to determine size and location of fistula.

Post-operative care: Family planning unit does counselling (for everyone) twice a week at the hospital. For VVF clients, there is an emphasis on spacing children and family planning methods available (pills, depo and Norplant are most com-

mon; women who live far away want long-acting methods). VVF clients are asked to return a month after their procedure, but only the ones with problems return. HIV “sensitization” is given to VVF clients; VCT centre is on site, but it is not used very much, so now the hours are reduced only to Thursdays.

Rehabilitation/reintegration: No community services or programmes.

Community outreach: The hospital plans for the visits of the surgeons and tries to set aside funds for any additional materials needed. They use two local FM radio stations and are flooded by response to these messages. There are regular community outreach workers who are paid by the district.

Support at the policy level: The district is starting to appreciate what a big problem VVF is. The problem, in the words of the medical superintendent, is that they are used to a small investment having a big impact—like nutrition or family planning—but VVF is the opposite. The investment is large and it may fail.

Estimated fully-loaded cost per procedure: Unknown.

Resources: The Ugandan government supports them through the MOH; they also receive some funding from Lira district for special procedures/specialist visits, which VVF is considered to be. Visiting doctors bring all of their own equipment.

Barriers:

- Inadequate amount of space is a big problem. Sometimes, they try to take some space from the eye clinic, put more women in the same room/bed or use the corridor and office space for beds.
- When fistula clients are operated on, all other surgeries must stop, except for emergencies.
- Equipment.
- Training opportunities for interested medical and nursing staff.
- Strong local belief about giving birth at home exists, so even though services are free, women want to deliver at home. Only about 20 per cent deliver in the hospital.
- Hospital needs separate budget/funding for VVF special needs, like extra IV fluids. If their own

doctors were able to perform VVF repair, the hospital would need to purchase the equipment.

D. Nsambya Hospital, Kampala visited 9 May 2002

Size: 360 beds.

Medical staff: Among other medical staff, there are three consultant gynaecologists. The medical superintendent is also a gynaecologist; all of these staff conduct VVF repairs. All received some on-the-job training from an Irish physician who was previously posted there.

Caseload: Currently, Nsambya gets about two to three cases per week. They used to see a lot more, but in 1996, when the economy started to decline, suddenly many people could not pay even a little, so the caseload dropped. Last year, the staff performed 60 repairs. Previously, however, they did 120 per year. Now, the most difficult cases in the area are coming to Nsambya. Ten to 15 per cent of the obstetric fistula cases they see occur from poorly managed labour in a health unit, and poorly handled C-sections. Fistula repairs are done on a regular basis.

Provenance of clients: Although many come from the area, many also travel a great distance (from as far away as Mbarara) because they know of Nsambya and its good reputation.

Typical client profile: Some are young (16 to 19), but the majority are between 20 and 30. Most come with a relative, but some come unattended. The nurses have to cope with a range of needs, including obtaining food for everyone who arrives with a client.

Assessment and screening process:

- Haemoglobin is checked.
- Infections are checked.
- Chest x-rays are done, if needed.
- Women are assessed under general anaesthesia in the operating theatre to determine the exact nature and location of the fistula.

Post-operative care:

- Women are placed in a prone position for two weeks.
- A series of clamping regimens are used to retrain the bladder.

- If there are no signs or symptoms of HIV/AIDS, it is not mentioned.
- The doctors counsel the male partners of the fistula clients on the need to abstain.
- Clients are advised on need for C-section for subsequent pregnancies.
- Clients are informed about family planning, but no methods are given (providers noted that this is because it is a Catholic hospital).
- An HIV clinic at Nsambya runs on Wednesdays, so condoms can be obtained there.

Rehabilitation/reintegration: There are no specific community services available to women to help them reintegrate back into the community.

Community outreach: None specifically done on VVF, but people in the community are aware that obstetric fistula can be repaired at Nsambya. There is an organized outreach programme on immunizations, so perhaps VVF repair and prevention could be mentioned in this context, although one of the hospital's key donors is specifically concerned about immunizations.

Support at the policy level: Staff physicians are aware of some level of interest on the part of the MOH in this issue; the previous Minister came from a mountainous region where VVF was common so he was very interested, but now he is in a different position in the government.

Estimated fully-loaded cost per procedure: About \$120 USD, but the exact fee depends on how long the women end up staying, the interventions done and treatment given.

Resources: An anonymous local group has offered to pay \$400 USD a month to the hospital to support fistula repairs. Although Mulago (also in Kampala) does some repairs, there "women end up lying around for a long time." Fees are charged to clients, but they cannot always pay.

Barriers:

- More training is needed for doctors, especially on the management of difficult cases.
- Fees need to be reduced, so more women can come for repairs.
- More emphasis needs to be on fistula prevention.

Key Contacts

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