REPORT ON THE MEETING FOR THE PREVENTION & TREATMENT OF OBSTETRIC FISTULA

LONDON

JULY 2001

UNITED NATIONS POPULATION FUND

AVERTING MATERNAL DEATH & DISABILITY PROGRAM, COLUMBIA UNIVERSITY

INTERNATIONAL FEDERATION OF OBSTETRICS & GYNECOLOGY

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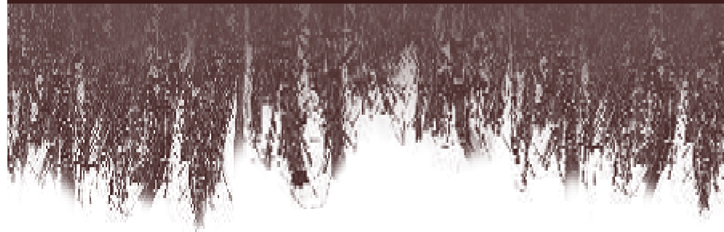

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PREVENTION
FISTULA
TREATMENT

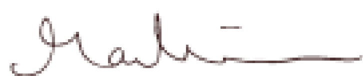
FOREWORD

OBSTETRIC FISTULA is the most devastating morbidity of pregnancy. It primarily affects young, poor women whose families lack the means to access quality maternal care. Many of these women remain hidden in remote villages. Even those who have access to surgical repair face long waits, as the demand is far greater than the capacity of existing facilities. In many areas, repair services simply do not exist.

Fistula was once common throughout the world. Over the last century, Europe and North America have essentially eradicated the condition through improved obstetric care. However, in many countries, particularly in Africa and parts of Asia, unacceptably high numbers of women are afflicted. Because the industrialized world and many developing countries have been successful in their fight against fistula, we know that workable solutions exist, even in resource-poor countries.

The United Nations Population Fund (UNFPA) has partnered with the International Federation of Obstetrics and Gynecology (FIGO) and Columbia University's Averting Maternal Death and Disability Program (AMDD) to lead an international campaign to prevent new cases of fistula and to provide much-needed services for women who suffer from it. This includes supporting the valiant programmes already in place throughout Africa, and fostering increased access to services through the creation of new centres to help women with fistula.

This report reviews the first meeting of international fistula experts in London in July 2001, which launched this initiative and focused on concrete actions to alleviate the suffering of affected women. It is our sincerest hope that together we can work to make fistula as rare in Africa and in all developing countries as it is in the industrialized world. We know that new partners will join us in this worthwhile initiative.



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EXECUTIVE SUMMARY

PREGNANCY AND CHILDBIRTH should be a special time in the lives of women and families. Unfortunately, it can also be a time of great danger. Throughout the world, half a million women die from complications of pregnancy or childbirth every year. These deaths tear apart families, leaving children without the life-saving protection of a mother. For every woman who dies in childbirth, many more remain alive, but scarred by permanent disabilities.

Obstetric fistula is, without a doubt, the most severe of the pregnancy-related disabilities. Beyond the serious physical consequences, the condition has a devastating impact on the social status of a young girl or woman.

An obstetric fistula—a hole between the vagina and either the bladder or the rectum—leaves a woman incontinent. She suffers from a constant wetness that causes genital ulcerations, frequent infections and a terrible odour. Reliable data on the prevalence of fistula are virtually non-existent, although the problem has been reported throughout Africa and some parts of Asia and most likely exists elsewhere as well. However, because the condition is shrouded by shame and dishonour, many women suffering from fistula remain hidden.

Marriage and early childbearing by adolescents and young women often contribute to the formation of fistulas. Many young girls who are given in marriage too soon will have their lives circumscribed by the social stigma of fistula. In addition to the physical discomfort they bear, such women are often ostracized by their communities and may be left struggling to survive, abandoned by their husbands and families. Most will remain childless.

The poverty and lack of access to obstetric care that often lead to fistula also prevent affected women and girls from having the fistula repaired. UNFPA is working on several fronts to address the many issues that lead to fistula. In the social arena, the Fund advocates against too-early marriage and childbearing. In the health care arena, it supports skilled attendance at birth and wider access to emergency obstetric care.

UNFPA also recognizes the urgency of addressing the needs of those women and girls already scarred by fistula. UNFPA is pleased to have joined forces with the International Federation of Obstetrics and Gynecology and Columbia University's Averting Maternal Death and Disability Program to help women living with fistula. This alliance recognizes the tremendous contribution of practitioners who have repaired fistula with limited support for decades already, and who still face a tremendous backlog of cases. We hope to assist them in their efforts.

On 18 and 19 July 2001, a working group of international fistula experts met in London and developed a programme of action to improve existing services for fistula repair, raise awareness

of the issue, and prevent new cases. Our intention is to prevent the conditions that lead to fistula, whenever possible, and increase access to high quality services for their repair. Some health institutions have been extremely successful in this regard. The Addis Ababa Fistula Hospital, for example, reports a 93 per cent success rate for surgical repairs, which has allowed thousands of women to resume full and normal lives.

The focus of the current initiative—the name of which is to be discussed—is to provide repairs to alleviate the suffering of women already affected by fistula. It will include monitoring and evaluation of existing programmes, but is not intended as a research project to determine the incidence and prevalence of the condition. Accurate numbers are difficult to obtain because women with fistula often remain hidden. However, studies done by non-governmental organizations, hospitals, academic investigators and governments will be used to guide programming. Members of the working group will also periodically review the literature to ensure that all new findings are incorporated into programming.

Priority action points for this initiative:

- **Provide direct support** to the Family Life Centre in Nigeria and the Addis Ababa Fistula Hospital in 2001.
- **Catalogue existing services**, beginning in 2001, and select appropriate sites for expansion or renovations that will increase surgical loads or accommodate more patients and staff.
- **Identify the needs** at selected sites for expansion, including physical plant changes, equipment and staffing.
- **Establish proper training** by:
  - Promoting a team-based approach that includes surgeons, nurses, social workers and other ancillary staff.
  - Following up with trainees to evaluate their new skills and advanced training needs.
  - Establishing sufficient funding for training fellowships.
- **Work with local health systems** to reduce or waive fees for emergency obstetric care and fistula repairs for those in need.
- **Promote transportation schemes**, especially community-funded ones, for women who need fistula repairs.
- **Raise funds** in order to provide free or heavily subsidized fistula repairs by laying the groundwork for a “fistula fund” designed to cover the cost of fistula repairs at multiple sites.
- **Encourage broader partnerships** by contacting other parties interested in contributing resources including the UK Department for International Development and the American College of Obstetricians and Gynecologists.

Additional interventions needed to ensure long-term progress:

- **Promote government awareness** of fistula and work to develop the political will for creating change. Work with governments to enforce policies that raise the age of marriage and promote family planning, access to emergency obstetric care, skilled attendance at birth, and support for fistula repair centres.
- **Work with communities** on campaigns that address the dangers of prolonged, obstructed labour and the appropriate interventions.
- **Encourage general advocacy** about fistula, including sensitive, appropriate media coverage.

REPORT ON THE MEETING

THIS WAS THE FIRST MEETING OF A DISTINGUISHED GROUP OF EXPERTS on obstetric fistula convened by the United Nations Population Fund, the International Federation of Gynecologists and Obstetricians and Columbia University's Averting Maternal Death and Disability Program.

The agenda focused on how to stimulate international action to prevent and treat fistula, particularly in Africa. Opening the meeting, Lord Naren Patel, vice-president of FIGO, stressed his organization's commitment to work through existing networks of obstetricians and gynecologists to promote an understanding of fistula. He also highlighted the need for training in order to ensure that quality repairs are available.

Dr. France Donnay, acting chief of the reproductive health branch, technical support division at UNFPA, expressed a similar commitment on behalf of UNFPA to address fistula. She acknowledged that the participants were not representative of everyone working with fistula, but that they represented many of the key players.

The third sponsor in this new initiative, the AMDD Program at Columbia University, was represented by Dr. Deborah Maine, its director, and Dr. Barbara Kwast, special advisor.

The goals of the initiative, as outlined by Dr. Donnay, include improving access to high quality treatment for affected women and easing the social integration of women who have been repaired as well as those who remain affected. This meeting primarily addressed the first point.

Objective 1

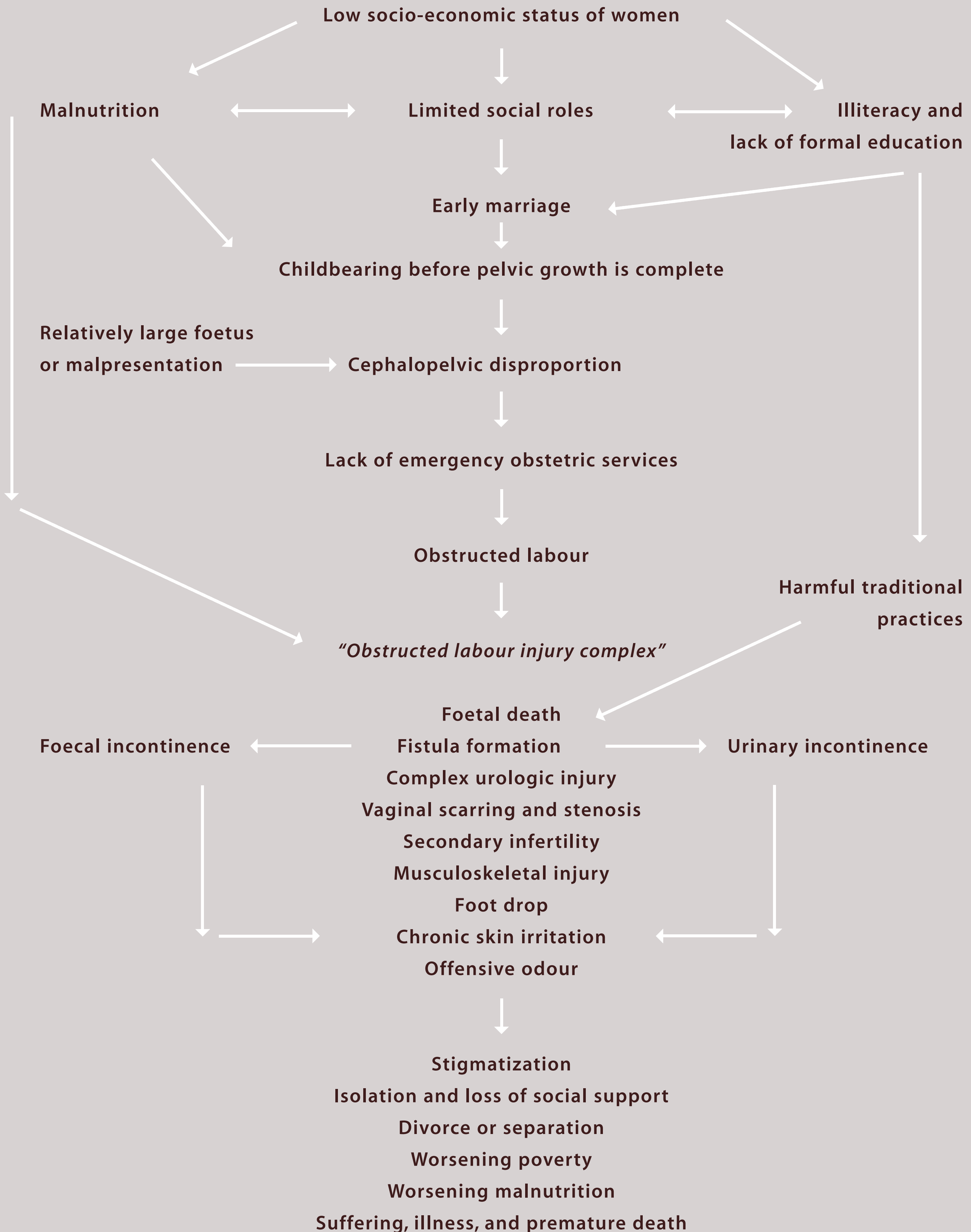
Recognizing the outstanding work already done in Africa by many organizations and individuals, the initiative seeks to bolster the two centres for fistula repair in Africa by increasing their capacity for treatment of patients and training personnel from other countries.

Objective 2

Creating additional regional centres for fistula repair, where needed, as an adjunct to hospitals that already provide maternity care. This may require facility improvement, management development, comprehensive training, and community advocacy.

Objective 3

Establishing funds to increase the availability of fistula repair and to train surgeons, midwives and nurses, and social workers working with fistula patients.



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TAKING STOCK

Some of the world's most prominent experts in the surgical treatment of fistula—Drs. Catherine Hamlin, Ann Ward and John Kelly—shared their experiences with the group:

ETHIOPIA

Speakers: Dr. Catherine Hamlin
Ruth Kennedy

The Hamlin Fistula Hospital began in the 1970's as a ward within a local maternity hospital, where some 30 fistula surgeries were performed in the first year. The centre has grown dramatically since then, and now treats about 1,200 women every year in a separate facility. While this work is significant, it addresses just a fraction of the 9,000 new fistulas that occur annually in Ethiopia alone. Although the repairs are free, many women remain untreated due to distance, lack of information or insufficient funds to travel to the hospital.

Many of the cases seen at the hospital are quite complicated, and some occurred as many as ten years ago. Of the women who are repaired, many of the more severe cases require ileo conduits—stomas that direct the ureters to drain into an external bag. Because many such patients rely on the hospital for supplies, they cannot return to their villages. The hospital attempts to provide these women with safe and comfortable living situations. Another complication of prolonged and obstructed labour common to women with fistulas is "foot drop" or damage to the nerves that run through the pelvis. Many of these women require long-term physical therapy to regain the ability to walk normally. The hospital now has several wards to accommodate these women for extended stays, as well as for others who face long waits for surgery.

To date, the hospital has provided repairs for nearly 20,000 women. Many of these women serve as "ambassadors" and reach out to other women with fistula upon returning to their villages. Other women, many of them long-term patients, have been trained to perform medical and nursing duties at the hospital itself, and comprise a large percentage of the nursing and ancillary staff.

Dr. Catherine Hamlin

The hospital provides training for Ethiopian post-graduate students who spend two months in training. Usually two students are at the hospital at any given time. While its focus is training local doctors, the hospital also provides training for doctors doing fistula surgery in other developing countries. However, there is a long waiting list for foreign doctors who want to be trained.

The hospital staff makes occasional trips to regional sites within Ethiopia to treat fistula. Complete medical teams, including doctors, nurses and all of the necessary medical supplies, are brought to these sites for a predetermined period of time to reach women who are unable to travel to Addis Ababa. Plans for semi-permanent bases for fistula repairs are being considered. Outreach visits and the hospital itself are advertised primarily through word of mouth, although hospitals and health centres refer patient through Ethiopia's established referral system. The hospital staff would like to expand outreach both nationally, by creating several satellite centres, and internationally.

The hospital meets its operating expenses but does not have the funds for expansion. Current

annual operating costs total about US$400,000 per year, with per surgery costs of about $350. Expansion would require an additional $100,000 per year plus start-up costs.

The Government of Ethiopia supports the hospital's long-term care for women unable to return to their villages. The government recently gave the hospital 60 hectares of land for homes and a rehabilitation unit for long-term and chronic patients.

NIGERIA

Speakers: Mary Kanu, Dr. John Kelly, Dr. Nana Tanko, Dr. Ann Ward

Nigeria faces a daunting challenge in combating fistula. Due to recent problems with health service delivery, including strikes by physicians and nurses, many basic services are unavailable, and access to emergency obstetric care is decreasing. This will likely increase the incidence of fistula.

Already Nigeria has 800,000 to one million unrepaired fistulas, according to government statistics. And the country seems to be backsliding, with a rising incidence of new cases and an increasing backlog of unrepaired fistulas.

The Family Life Centre, a specialized fistula repair centre located in Akwa Ibom State, has historically relied heavily on funds from the local division of Mobil Oil. Unfortunately, since the Mobil/ Exxon merger in 1999, the centre no longer receives this aid. They do receive some supplemental funding from the Government of Ireland.

Previously, the Family Life Centre was very involved with surgical training. The Nigerian National Foundation on Vesico-Vaginal Fistula (VVF) sponsored the training of at least 87 surgeons, but very few are still performing repairs. Reasons for this include the lack of support for salary and housing, as well as medical equipment and supplies. Many of the doctors that were trained cannot perform fistula repairs because they lack adequate access to operating theatres, a situation that has undermined the sustainability of services.

The Family Life Centre would be willing to offer surgical training again, but this would require significant financial support and an increase in nursing and paramedical staff, plus salary and housing for the additional personnel.

Government negotiations are under way to create policy and financial support for repairs. President Obasanjo of Nigeria and several other high-level politicians recently have taken an interest in fistula and indicated a willingness to seek policy actions. To support these efforts, the Nigerian National Foundation on VVF is now working on a needs assessment to determine how the government can contribute.

The Nigerian National Foundation on VVF was established to counteract a lack of concern about the issue and seeks to create greater public recognition of fistula as a social and cultural issue as well as a medical concern. The foundation recently received funds from the Interchurch Organization for Development Cooperation, a foundation in the Netherlands, to continue the work, including public education campaigns to prevent early marriage and support for midwifery in rural areas.

In addition to the Family Life Centre, several other facilities in the country provide fistula repairs. Most notably, the Evangel Hospital in Plateau State surgically repairs more than 300 fistulas per year.

Even with repair centres working to capacity, they will not be able to clear the large backlog of cases. Many are concerned about attracting too much attention to their work before increasing

their capacity, because in the past, thousands of women arrived at centres for repairs after hearing radio advertisements. To avoid similar disappointments, the centres need to expand their services before advertising them.

TANZANIA

Speaker: Maggie Bangser

A number of government, private and mission hospitals in Tanzania repair fistulas. In addition, educational campaigns in the past few years have increased awareness of the problem. Nonetheless, many areas are without fistula services and local experts believe that most women living with the condition cannot get repairs.

Since 1996, fistula has received the attention of the Bugando Medical Centre, the second largest referral facility in the country, and the site of a new teaching hospital. The hospital offers repairs and is beginning to train local surgeons. In 1997, the Bugando Medical Centre established a special fistula repair unit within its OB/GYN unit. Initially, several local surgeons and nurses were sent from Bugando to the Addis Ababa Fistula Hospital for training. A team from Addis Ababa also traveled to Bugando to train staff and to expose other providers from nearby areas to fistula repair and care. Based on the experience at the Bugando Medical Centre and other hospitals, a new fistula training programme in Tanzania focuses on post-training and provides an opportunity for doctors to practice their skills.

The lack of access to obstetric care that contributes to fistula in Tanzania goes beyond a lack of services. As in much of Africa, user fees also deter women from seeking care. In order to be successful, any fistula programme will need to address the critical issue of cost.

Possibilities for improving fistula repair services in other regions mean working with two other major hospitals: Kilimanjaro Christian Medical Centre (KCMC) in Moshi and Comprehensive Community Based Rehabilitation and Training (CBRT) Disability Hospital in Dar-es-Salaam. In addition to the large, government hospitals, several small mission hospitals throughout the country do occasional repairs. The Women's Dignity Project has inventoried these services.

Visiting surgeons assist many of the smaller mission hospitals with fistula repairs. While this increases the availability of services in underserved areas, it sometimes means a lack of adequate patient follow-up. Once the visiting surgeon moves on, repairs cease, and patients must wait until the arrival of the next surgeon. When visiting surgeons can stay for several weeks, their contribution is greatly enhanced.

Transportation is another critical issue. One cost-effective strategy is to bring women to referral centres instead of transporting entire medical teams to more rural areas. Creating an air-transport service with, for example, an interested mission aviation programme, might be a way to accomplish this.

The Women's Dignity Project seeks to affect the policy and health service delivery context surrounding the problem. It analyzes, for example, how—and how much—public financing goes to basic and tertiary medical care, whether the priorities of people living in poverty are reflected in the allocation of public funds, and whether expenditures are transparently reported.

PREVENTING FISTULA

PREVENTION OF FISTULA HAS TWO MAIN FOCI: the prevention of early pregnancy and improving access to essential obstetric and basic health care services. Both issues are directly linked to poverty. Although large-scale poverty reduction activities are clearly outside the scope of this initiative, whenever possible, it should support poverty reduction activities and policies and advocate against early marriage and childbearing. A primary intervention will be addressing the lack of access to timely obstetric care. This will require addressing each of the three classic delays: the delay in the decision to seek medical care, the delay in reaching a care facility and the delay in receiving care at the health care facility.

The first delay often arises from the lack of trained birth attendants who can recognize impending complications. In many unattended births, the woman and her family do not recognize life-threatening complications early enough to access treatment. Another cause of this initial delay may be the fear of high costs associated with seeking medical treatment.

The second delay involves transport: treacherous roads, long journeys and/or the expense or unavailability of transportation.

The third delay—in getting care at the facility—is the most critical, and should be addressed first. It requires ready access to surgical supplies, personnel and operating theatres. In many cases, it may mean expediting or waiving the hospitals' fee requirements.

In summary, fistula prevention requires good management of labour with a partograph, early diagnosis of prolonged and obstructed labour, and timely referral to an obstetric care facility. At facilities, prompt surgery should be available. The waiver of hospital user fees for maternity care can facilitate this.

Since men are often responsible for decision-making and seeking funds for transport to the hospital, promoting the involvement of men—potential fathers as well as religious and community leaders—is crucial to widening access to emergency obstetric care. In some places, however, the lingering belief that a woman's unfaithfulness to her marriage is responsible for a difficult labour may complicate the decision to transport her to an emergency obstetric care facility.

Action Points

- Continue to promote skilled attendance at birth through training, deployment and support of nurses, midwives and doctors.
- Work with local health delivery systems to reduce or waive user fees for emergency obstetric care.
- Collaborate with communities to prevent early marriage and promote referral of women for obstetric care.
- Work to ensure that local emergency obstetric care facilities are well staffed and well equipped.

ADVOCATING FOR CHANGE

ADVOCACY IS A CORE COMPONENT in addressing fistula. On a global scale, advocacy should aim to raise general public awareness on the issue and target the medical community in particular. UNFPA, FIGO and AMDD are uniquely positioned to promote the training of surgeons and nurses to work in this area and for mobilizing funding for fistula surgery. They can also build awareness of the problem.

Although media coverage has succeeded in bringing attention and funding to the issue of fistula in the past, the goal now should be to produce concrete programmes and activities, not simply media events. Through judicious and appropriate use of the media, the initiative can effectively advocate for fistula funds and programmes with the ultimate goal of improving access to services.

Audio-visual materials that put a human face on the issue will help attract donors from outside the medical community. Though this is a very touching topic, care must be taken not to portray women with fistula as victims, but as survivors instead.

UNFPA has already created a Video News Release and will produce an advocacy video for journalists that will be available in several formats. There are also two good videos about fistula available through the BBC. Media advocacy will include bringing reporters and donor country journalists to the field. This will help to bring attention to the issue in the print media and radio as well.

At the government level, advocacy will focus on influencing policies that address legal age at marriage and access to maternity care, as well as direct support for fistula repair centres.

Community level advocacy is important and should include both large-scale communication campaigns for behaviour change and community-based education programmes led by health care workers and former patients. Such efforts should involve community leaders, young men, religious leaders and older women who are likely to be mother-in-laws. They should focus on making sure that the community understands the dangers of prolonged and obstructed labour so they will support appropriate interventions. Another important issue is organizing community funding schemes to cover the cost of hospital transport.

Action Points

- Encourage general advocacy about fistula, including sensitive, appropriate media coverage.
- Promote government awareness of the problem of fistula and work to develop the political will for creating change.
- Work with governments to enforce policies that raise the age at marriage and promote family planning, access to emergency obstetric care, skilled attendance at birth, and support for fistula repair centres.
- Work with communities on campaigns that address the dangers of prolonged, obstructed labour and the appropriate interventions.

BUILDING ON EXISTING CAPACITY

THE EXPERIENCE OF THE FISTULA REPAIR CENTRES in the Family Life Centre in Nigeria and the Addis Ababa Fistula Hospital in Ethiopia can serve as examples for supporting existing centres throughout Africa. Successful expansions entail additional training as well as physical improvements.

Physical facilities: Expanding physical facilities includes renovating operating theatres and wards, and creating hostels for patients awaiting surgery or rehabilitation facilities for long-term patients. A fistula centre should also include free or affordable housing for staff and trainees. A reliable source of supplies and equipment is another essential component of physical capacity, as is the ability for regular facility maintenance.

Personnel: Local professionals lend critical support to fistula repair facilities, whether by providing referrals, or by offering services or training. In addition to showing commitment to their work, facility staff should be able to provide outreach. This gives the staff new opportunities for training and can also benefit women in remote areas.

Both the Addis Ababa Hospital and the Family Life Centre have trained former patients to provide nearly all of the nursing care for fistula patients. Many other patients work as community activists on the issue of fistula. In Addis Ababa, one former patient was trained to perform fistula repairs and has become one of the centre's most valuable surgeons.

Action Points

- Promote the expansion or renovation of physical facilities to allow for increased surgical loads and to accommodate increased patients and staff.
- Promote the proper training of personnel for adequate pre- and post-operative care.

Some patients need long-term physiotherapy following the fistula repair to regain the use of their legs.

TRAINING MORE PROFESSIONALS

TRAINING IS A PRIORITY because of the increasing number of cases and the lack of skilled specialists. Because the need for skilled surgeons is most acute in Africa, trainees from this continent should be selected rather than using resources to train foreign doctors who may not remain in the area for extended periods. Candidates for training programmes should understand that training includes follow-up, advanced training and evaluation, and that afterwards they will be expected to practice in their respective regions. Programmes may also benefit from training more women.

A team-based training approach—one that includes the nursing staff, midwives and surgeons—may be far more effective than training staff members separately. Training nurses is critical, as many fistula surgeons consider skilled post-operative care an essential component for success. A team-based approach can be implemented by sending surgeons and nurses from existing centres to new sites as trainers. Training at least two surgeons at each new site, along with a strong contingent of nurses, is preferable to investing too heavily in a single surgeon.

Training programmes should offer courses of varying levels depending on the needs and availability of each institution and individual. At a minimum, surgical training should entail one to three months of clinical work, and at least ten surgeries. Recently trained surgeons should be advised to undertake only simple repairs for the first year. Surgeons encountering cases that are more complex may need secondary training or an advanced course. This is particularly relevant, as the severity of fistula cases seems to be increasing.

Many doctors get training and experience at the Hamlin Fistula Hospital.

Selection of surgical trainees should be based upon the following criteria:

- The willingness and capacity of doctors to perform surgery free of charge
- Skill in pelvic surgery
- The availability of trained nursing staff
- The availability of a supportive infrastructure, such as an operating theatre, post-operative ward and supplies
- Government permission to attend training, and a commitment to support repair activities after training

Evaluation of training: Training should include follow-up. This entails monitoring to ensure that trainees are, in fact, performing fistula repairs, tracking the number of surgeries and assessing the quality of care. Follow-up can be accomplished by evaluation visits, questionnaires, the use of process indicators (such as availability of nursing staff and equipment), and case log reviews. Often the scarcity of supplies, equipment and funds prevent trained surgeons from operating. Thus, careful monitoring of these post-training needs is important. Also, identifying areas where a lack of supplies hinder the availability of repairs can help partners target financial and advocacy assistance cost-effectively.

Training cost and capacity: Though the Addis Ababa Fistula Hospital and the Family Life Centre appear to be important sites for training, several limitations will have to be addressed. Already, the Addis Ababa hospital is training a total of 12 Ethiopian and ten foreign surgeons a year. Increasing capacity will require the development of satellite centres, and more beds and another operating theatre in the main hospital. Adding another full-time physician to the core staff to help as a trainer would also be helpful. Only four full-time surgeons work at the hospital.

In order to add the capacity for surgical training at the Family Life Centre, it will be necessary to significantly increase the surgical and nursing staff at the hospital.

Funding for training fellowships is necessary for successful programming. In addition to creation of a fistula fund, professional societies, universities, and government matching funds may be viable sources of support for trainees.

A group of patients waiting to leave the Hamlin Fistula Hospital.

Action Points

- Promote a team-based training approach, including surgeons, nurses, social workers and other ancillary staff. This may involve bringing trainers to new sites rather than bringing trainees to an existing centre.
- Encourage training of women surgeons.
- Establish sufficient funding for training fellowships.

SUPPORTING NEW FISTULA CENTRES

Ideally, fistula centres should be evenly distributed geographically. However, promoting new centres in some areas may require more start-up work than approaching an existing centre in another region and helping it to expand. These factors should be carefully weighed before taking action.

Many surgeons have already been trained, and are willing to perform repairs, but have no hospital or government support. Finding these surgeons and supporting them in their current environment is an efficient and effective way to take advantage of their expertise. Finding trained and committed individuals—both doctors and administrators—willing to take leadership in the operation and sustainability of fistula repair centres is critical. Well-trained nursing staff is another crucial element in the success of a repair centre, as post-operative nursing care plays a large role in the success of fistula repairs.

A mentoring process that connects new surgeons and facility directors to the centres that have been in operation for many years can reduce the many difficulties of start-up and maintenance. This may include mentoring potential administrators at existing sites.

The facility itself is another important element in creating a sustainable fistula centre. Any new centre should include basic facilities, such as access to an operating theatre and a dedicated ward for fistula patients. There does not necessarily need to be a dedicated operating theatre, but dedicated time must be allotted. Ongoing access to equipment and supplies is another requirement.

A key issue is the relative efficiency of creating new centres within existing facilities compared to creating free-standing facilities. Though each has its advantages, the group agreed that a dedicated ward and operating theatre within an existing facility is the most efficient solution in the beginning. However, a separate ward for patients both before and after surgery increases patient safety and facilitates psychosocial interventions. It will mean that some lab tests and radiology procedures will have to be referred. If a free-standing facility can be located near a larger hospital, it may be easier to both utilize and support the services provided there, and also provide an opportunity to

strengthen its entire OB/GYN unit.

A free-standing centre or a dedicated unit within an existing hospital may be able to waive mandatory user fees to ensure that women can afford repairs. In practice, many institutions start within an existing facility, grow, and then need to be transplanted to a larger or separate facility.

The Addis Ababa Fistula Hospital is planning to create a series of satellite centres in Ethiopia. Permanent support staff will be available at the satellites to care for women before and after their repairs, while surgeons would be available only a few months each year. This will serve to improve access to repairs for women unable to travel to Addis, and also expand training opportunities for surgeons and nurses.

A new centre also needs to be able to provide services free of charge or at low cost. Unless surgeries are subsidized, it will be difficult for women to pay for them, and the centre's potential will be limited. The establishment of a fistula fund or an endowment will be an important component of setting up a new centre.

Potential sites for expansion include:

- Satellite centres associated with the Addis Ababa Fistula Hospital
- A small hospital with a five-bed ward in Ethiopia
- Evangel Hospital in Plateau State, Nigeria
- A small programme in Somalia that sent two doctors to Addis Ababa for training in September
- Mercy Ships (London)

Countries for potential expansion:

- Chad
- Ghana
- Kenya
- Liberia
- Malawi
- Mali
- Mozambique
- Sudan
- Tanzania
- Uganda
- Zambia

Action Points

- Conduct rapid survey to catalogue existing services and select sites for expansion.
- Identify the needs at selected sites for expansion, including physical plant changes, equipment and staffing needs.
- Ensure that funds are available for fistula repairs.

ADDRESSING THE COST ISSUE

MOST WOMEN ARE UNABLE TO PAY for their own fistula surgeries. In creating any new centre it is important to ensure there is a mechanism in place to cover or at least help with the cost of surgery. Based on estimates by existing facilities that perform this surgery, the cost of an individual fistula repair is about $350-$400, including equipment, supplies, surgery and post-operative care. This figure is clearly beyond the reach of most girls and women who need help. It is also an easy way to present funding needs to the general public.

Many strategies have been used to address mandatory user fees in parts of Africa. In some cases, the small fees collected are an important source of funding for the centre, so it is not always possible to do away with them completely. In some hospitals in Tanzania a sliding scale method has been instituted. Women who can afford to pay do so. Otherwise, the hospital or a fistula fund will cover the required fees. In other situations, the cost of the surgery is covered but the patient is responsible for registration fees.

It is essential to work with local hospitals on the fee scale. Many of the hospitals have put a great deal of thought into the system, and understanding their rationale may help to establish a new system that meets the needs of both the hospital and the fistula patients.

Any negotiation of fee scale with local hospitals should include a discussion of the fees for emergency obstetric care. In many countries, the user fees required for Caesarian sections result in delayed care and contribute to the formation of a fistula. Thus, a focus on removing user fees for fistula repair without addressing the fees for Caesarian sections, which could prevent the problem, is not efficient.

Travel costs are also a major concern to women with fistula, and should be addressed.

Action Points

- Promote discussion with local hospitals on current systems for user fees related to emergency obstetric care and fistula repair.
- Address alternative fee scales to ensure that all women can access the necessary care.
- Lay the groundwork for a “fistula fund” designed to cover the cost of fistula repairs at multiple sites.
- Explore ways to cover the transportation costs of women seeking fistula repairs.

RAISING FUNDS

THE CREATION OF A FISTULA TRUST FUND, to which interested groups can apply, was mentioned. This will be further discussed between the partners of this initiative and other potential stakeholders. It is advisable to target different donors for the two main types of funding needs: the expansion of health facilities, which can be supported by governments and international donors, on the one hand, and the fistula repairs, which are more likely to elicit the interest of the general public.

UNFPA, FIGO and Columbia University's AMDD Program are committed to devote a total of $750, 000 each to a fistula fund over the years 2001, 2002 and 2003. Any other organizations wishing to participate will be encouraged to participate at this level, if possible.

UNFPA and AMDD will use earmarked funds from their contribution to support a project development exercise, beginning in 2001, to assess the needs and opportunities for establishing fistula repair centres in Africa. Based on the results of the assessment, action programmes may begin in early 2002. Funding also includes direct assistance to both the Addis Ababa Fistula Hospital and the Family Life Centre in Nigeria in 2001 from UNFPA and AMDD.

Several other organizations will contribute labour and resources to the fund. For example, WHO will provide guidelines and teaching/training materials for medical personnel. The International Confederation of Midwives (ICM) can work on advocacy and fundraising. ICM is particularly well suited for advocacy, can add a session on fistula at their upcoming international congress, and work on training the staff of Mercy Ships in London.

It should be acknowledged that hospitals supporting fistula repairs, even those reimbursed for operations, also provide extensive in-kind resources including water, electricity, administration and management.

Action Points

- A fistula fund could be established with contributions from the three initial partners, UNFPA, FIGO and AMDD, pending more detailed discussions.
- A fundraising strategy should be developed.
- Direct support will be provided to the Family Life Centre and the Addis Ababa Fistula Hospital in 2001.
- Project development activities will begin in 2001.
- Other interested parties will be contacted, including WHO, the Department for International Development (UK) and the American College of Gynecologists.

NEXT STEPS

- The July 2001 meeting will be considered the first in a series of meetings of the fistula initiative advisory group, which will convene annually to review progress and needed actions. Next year's meeting will take place in Addis Ababa.

- A baseline needs assessment will be conducted in up to eight countries in Africa in 2002. This will help identify the existing capacity for training and repairs and new locations for work.

- Outreach to francophone Africa, including prompt translation of materials into French, will begin in 2002.

- Guidelines on clinical management of fistula will be finalized.

- Documentation of activities will begin in 2002, including case studies and advocacy materials to be distributed to the media and potential stakeholders.

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