

ETHIOPIA



Fistula Pre-Repair Center Model in the Amhara Region of Ethiopia

WHAT IS FISTULA?

Obstetric fistula is a childbirth injury, usually occurring when a woman is in labor too long or when the delivery is obstructed, and she has no access to a cesarean section. She endures internal injuries leaving her incontinent, trickling urine and sometimes feces through her vagina.

Fistula Care works to prevent fistula from occurring, treats and cares for women with fistula, and assists in their rehabilitation and reintegration. For more information about fistula and the Fistula Care project, visit www.fistulacare.org.

www.fistulacare.org

Introduction

The Addis Ababa Fistula Hospital (AAFH) has provided women fistula repair and rehabilitative services since 1974. In 2005 the hospital opened its first regional fistula repair hospital, Bahir Dar Hamlin Fistula Hospital (BDHFH), in the Amhara Region.¹ The BDHFH is a 44-bed facility on the same campus as the Felege Hiwot Regional Hospital in the city of Bahir Dar.

Since 2006, the United States Agency for International Development (USAID) has supported fistula treatment and prevention in Ethiopia through several projects:

1. A bilateral agreement with the AAFH to support treatment and prevention activities at facilities in Amhara, Tigray, and the Southern Nations, Nationalities, and People's Region (SNNPR)
2. EngenderHealth's ACQUIRE and Fistula Care projects, implemented by IntraHealth International
3. Pathfinder's Extended Service Delivery Project (ESD), implemented by IntraHealth International²

USAID's fistula project partners work with BDHFH and the Amhara Regional Health Bureau (ARHB) to support prevention outreach, identification of fistula patients, pre-repair care, postsurgical care, and community reintegration. To reach more women with fistula, three of the 179 health centers in the Amhara Region were identified to become pre-repair centers for the BDHFH. The three pre-repair centers are situated within the Adet, Dangla, and Woreta health centers; all are located approximately one and one-half to two and one-half hours by car from Bahir Dar and operate independently from the health centers.

Why Pre-Repair Centers?

Fistula pre-repair centers were established to help identify potential fistula repair patients, screen women for fistula repair, provide rehabilitation and relevant presurgery treatment to patients (to enhance their psychological readiness and improve their health status), and support reintegration after surgery. Centers are staffed by fistula mentors, who strengthen health workers' capacity to offer services for the primary and secondary prevention of fistula, including educating patients about the consequences of early births and about the importance of obtaining antenatal care, of seeking skilled care at the time of delivery, and of being transferred to a health care facility if labor is prolonged. Fistula mentors meet clients in the health center waiting areas and conduct health education sessions on a wide variety of topics. Mentors also assist with health center deliveries and conduct training and supportive supervision in the use of partographs.



Fistula survivors after successful surgery

The second important component of this project is the community outreach program, established with a focus on fistula prevention and referral for treatment. The fistula mentors identify community volunteers to form a Community Core Team (CCT) to educate and mobilize the community about fistula prevention, identification, and treatment.

The Pre-Repair Centers

Pre-repair center spaces were identified, refurbished, and opened at the three health centers in 2006. Each has a three-bed ward, toilet, shower, and small office. Experienced nurses were recruited, hired, and trained as fistula mentors. A five-day training program for the mentors and for health center doctors, nurses, medical officers, and midwives was conducted jointly by the AAFH and the fistula project in collaboration with the ARHB. Training focused on patient identification and care and on primary and secondary methods of prevention—antenatal care, delivery in health facilities, and early transfer of women experiencing prolonged labor to a health facility. While fistula mentors are primarily responsible for screening women who may have fistula, health center staff provide these services when the fistula mentor is away.

The CCT members identify women with urinary and/or fecal incontinence, notify the mentor, and organize

transportation to the pre-repair center. Sometimes, a woman self-identifies and gets to the pre-repair center or goes directly to the BDHFH.

Each center employs a nurse-aide who is a former fistula patient. The nurse-aide maintains the room, keeps patients clean, and assists with physiotherapy. She also provides meals, answers telephone calls, and contacts health center staff to evaluate new arrivals when the fistula mentor is out in the community or transporting patients. The nurse-aide lives at the center and provides significant psychological support to the patients.

Services at Pre-Repair Centers

Once a woman reaches a pre-repair center, she receives a package of essential services, including a physical examination to determine the cause of her incontinence. Women with uterine prolapse are referred to the health center and from there to

I was in labor for a long time and developed the fistula. [A community member] told me to get the surgery, but I did not want to go. The chairperson of the kebele telephoned the health center to get help for me. A car came and took me [to the pre-repair unit].

— Former fistula patient, age 22

the regional hospital for care. Mild stress incontinence is treated by teaching women pelvic floor exercises and arranging follow-up in three months. Women diagnosed with fistula are referred to BDHFH for surgical repair.

Women who have had fistula fewer than three months are catheterized, evaluated, and treated for incidental problems (as described below), discharged, and then scheduled to return for reevaluation after the three-month period has elapsed; if necessary, the women are referred for surgery. Women diagnosed with a fistula of more than three months duration are admitted immediately and undergo a variety of laboratory tests. All women are offered HIV counseling and testing.

All fistula patients receive a balanced diet, baths, and clean clothes. Medications are given as needed, such as iron tablets for anemia or mebendazole for intestinal parasites. Women are counseled about fistula, hygiene, family planning, HIV, and sexual relations after surgery. They are also counseled that they may not be cured with the first surgery. Physiotherapy (for foot drop or for contractures) and sitz baths are performed as indicated. Patients generally stay at the center for 5–14 days, depending on the degree of rehabilitation required to improve their readiness for surgery, as well as on the availability of a surgeon and a bed at BDHFH.

Once the BDHFH is ready to accept new patients, the mentors transport patients to the hospital. Women generally remain at BDHFH for 2–7 days prior to surgery and for two weeks after surgery. When ready for discharge, the patient returns to the pre-repair center for postrepair care (lasting from one day to one week). The patient is again counseled on family planning, HIV, future pregnancies (advice to wait two years to become pregnant again, to get early antenatal care, and to deliver at a hospital), and the need to abstain from sex for three months. She receives a card indicating the outcome of her surgery and is transported back to her community, where she is

encouraged to become an advocate for fistula prevention and care. The mentor will visit her monthly for six months, then quarterly, to assess her physical status and social reintegration. The center organizes transportation back to BDHFH for a six-month postsurgery check-up.

I gave the message about fistula to the church. Someone who heard me went to a neighbor and told her she could be cured. Before this, [we] thought this was not curable, that it was a curse.

— Male religious leader, CCT member

Community Program

A CCT was established in each of the communities in the health center's catchment area. Each of the 94 CCTs consists of 10–12 volunteers from a cross-section of key stakeholders: health providers and extension workers, school teachers/administrators, community and religious leaders, community-based reproductive health agents, traditional birth attendants, development agents, and representatives of community women's organizations. Community volunteers are trained on health care topics at the layperson level and on community mobilization around the issue of fistula. One-day refresher trainings for the volunteers are held once or twice yearly.

With the fistula mentor, each team develops a plan to disseminate fistula information. The CCTs meet monthly to review their activities and report on the past month's accomplishments to the health post representative, who is responsible for reporting to the pre-repair center and the district health office. CCT members receive a small per diem for meeting and training attendance and receive regular supportive supervision from fistula mentors. (Mentors usually conduct these supervision visits with the district health officer, the health center head, and the district health supervisor.) Turnover has been low, with most CCT members serving for two or more years.

The community team efforts reach people in a variety of settings, including churches, mosques, markets, schools, and homes. Religious leaders are particularly important for disseminating key messages on the disadvantages of early pregnancy, the value of antenatal care, the need to transport women who are in labor longer than 12 hours to the health center, and the importance of identifying and caring for fistula patients. Teachers provide fistula prevention and treatment messages at all grade levels and to both sexes. They also form Fistula Clubs to educate about fistula prevention, delay of early marriage, and discouragement of early pregnancy. Other community volunteers deliver key messages about the importance of family planning. Volunteers also help identify women with incontinence, easing their entry into care, and make postrepair

home visits to promote women's physical recovery and facilitate their social reintegration.

Project Results

Between July 2006 and September 2009, a total of 811 women were screened for fistula at the three pre-repair units. Of these women, 76% (614) were referred to BDHFH for fistula repair surgery.

The community team efforts have reached large populations in a variety of settings. Religious leaders have provided messages to as many as 200–600 people on a given day. Teachers have reached students in classrooms and parents through the fistula clubs. The health extension workers and community-based reproductive health agents have reached upwards of 30 people during 8–10 home visits a day. Between September 2007 and October 2008, the nearly 1,000 volunteers reached on average more than 2,000 persons each month.

Lessons Learned

The greatest strengths of this program lie in the fistula mentors, the CCTs, and the interrelationships between the two. The mentors are well-trained, knowledgeable, committed, and highly respected by the CCTs. In turn, most CCTs members are active in their outreach work and find the work rewarding (a factor that likely contributes to the low turnover).

Building the CCTs with a cross-section of respected leaders from existing community networks has increased awareness about fistula. Many community volunteers perceive their work to be contributing to changes in community attitudes regarding fistula, from negative and stigmatizing to supportive. Volunteers take pride in their work and appreciate the support from the mentors. The variety of volunteers facilitates the targeting of messages for different contexts and reaches large numbers of people. Home visits by community members are important in helping to reduce stigma and to enhance the reintegration of fistula patients. Community volunteers believe that early



Community leaders discuss fistula prevention

ETHIOPIA



ABOUT ETHIOPIA

Ethiopia is a large, primarily rural country with limited medical infrastructure. High fertility, low levels of antenatal care, and a dearth of skilled birth attendants contribute to high maternal mortality and morbidity. Fewer than 10% of births are delivered with the assistance of a trained health professional, such as a doctor, nurse, or midwife.³ The Amhara Region's population is estimated to be nearly 17 million. For every 5,000 people in this region, there is one health post, staffed by a health extension worker with limited skills.

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marriage is becoming less frequent and that more deliveries are occurring at the health center. CCT members derive great satisfaction from their work helping women in their communities. As one male volunteer in Adet noted, “these are our mothers. These are our sisters.”

Involving health center staff in fistula prevention and screening resulted in a working partnership between the pre-repair center and the health center. Staff help each other with coverage when necessary. The project's support to strengthen prevention services at the health centers included training in the use of the partograph, in fistula prevention and care, and in infection prevention practices.

Fistula mentors are skilled health care professionals who are connected to services at the health centers and are well-respected by health center staff and community volunteers. The separation of the pre-repair centers from most of the health center operations appears to have fostered a greater sense of ownership by the mentors, likely leading to higher quality services. While this pre-repair center model is certainly replicable, to be more sustainable, the mentors would be government employees rather than project staff.

The establishment of the pre-repair centers has helped prepare women for surgery. The BDHFH, nursing staff report that women who have had care at the center arrive at the hospital cleaner, educated about the procedures, healthier, and more psychologically prepared for surgery. The former patients who serve as nurse-aides provide valuable psychological support.

1. A second regional fistula repair center opened in 2007 in the Tigray Region..
2. Henceforth, we refer to the fistula activities carried out with USAID funding as the fistula project.
3. Central Statistical Agency (CSA) and ORC Macro. 2006. *Ethiopia Demographic and Health Survey 2005*. Addis Ababa, Ethiopia and Calverton, Maryland, USA: CSA and ORC Macro.

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