

FINAL REPORT OF FISTULA REPAIR TRAINING



CONDUCTED AT

JUBA TEACHING HOSPITAL, JUBA, SOUTH SUDAN.

BETWEEN

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ACRONYMS

AIDS	-	Acquired Immunodeficiency Syndrome
CPRH	-	Centre for Population and Reproductive Health
ELSS	-	Expanded Life Saving Skills
EmOC	-	Emergency Obstetrics Care
EUA	-	Examination Under Anaesthesia
GoSS	-	Government of South Sudan
HIV	-	Human Immunodeficiency Virus
LSS	-	Life Saving Skills
MLSS	-	Modified Life Saving Skills
MOH	-	Ministry of Health

RH	-	Reproductive Health
RVF	-	Recto Vaginal Fistula
SOGON	-	Society of Obstetrics and Gynaecology of Nigeria
STI	-	Sexually Transmitted Infection
TOT	-	Training of Trainers
UN	-	United Nations
UNFPA	-	United Nations Population Fund
VVF	-	Vesico Vaginal Fistula

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Thanks and all Glory must go to the Lord my God.

EXECUTIVE SUMMARY

Since Sudan gained independence in 1956, Southern Sudan has experienced two civil wars which resulted in significant destruction of physical infrastructure, loss of life, widespread poverty, gross underdevelopment and a total collapse of systems. Last year, following the comprehensive peace agreement; basic infrastructure and systems are being established.

Southern Sudan, with an estimated population of 9.7 million¹, HIV/AIDS prevalence is also rising especially with the current influx of people from neighbouring and other countries.

The lack of access to basic emergency obstetric services has led to a very high maternal mortality ratio (MMR), estimated to be 1,700 deaths per 100,000 live births and severe morbidity such as vesico-vaginal fistula, recto-vaginal fistula, foot drop etc. There is limited data on the extent of the problem but reports abound of huge numbers of women who have developed VVF reporting to health facilities. Many of the patients treated in Uganda and Kenya originate from Southern Sudan. One of the single most pressing challenges to the health sector in South Sudan is the lack of human resources to run the health sector

Discussions as part of the RH working group meeting centred on the poor state of maternal health care. This group which co-opted UNOCHA and UNIFEM acted and still acts as the fistula working group in South Sudan. These led to the decision to create three fistula treatment axes in South Sudan especially due to the large size of the land area. The first was to be sited in Juba.

Advocacy:

A coalition against fistula was formed with the active support of GoSS/MOH, members of the RH Working Group, UN agencies, especially UNIFEM and UNOCHA, Women's Groups in South Sudan and the media. Advocacy and education messages were developed and broadcast twice to thrice weekly on television programs (Juba Television) and radio stations (Liberty FM, Capital FM and Juba Radio). Discussions were held with leaders of women's groups in South Sudan (comprises 11 women's groups) at their headquarters in Malakia, Juba to solicit their support and assistance not only bringing patients but also in monitoring the women's small scale activities. A street announcer ("town crier") was employed to spread information regarding fistula throughout Juba and surrounding areas using an open van with mounted loudspeakers. The cost of the advocacy activities came to one thousand eight hundred and fifty dollars (\$1,850.00). UNFPA witnessed positive results from the use of these methods.

Background

Since Sudan gained independence in 1956, Southern Sudan has observed two civil wars. The last of the civil wars lasted for 21 years which only ended at the start of 2005. The civil war resulted in significant destruction of physical infrastructure, loss of life,

¹ UNOCHA, Starbase, April 2004.

widespread poverty, gross underdevelopment and a total collapse of systems. The Comprehensive Peace Agreement (CPA) signed in January 2005, has ensured the return of peace to South Sudan, a new government is in place, and basic infrastructure and systems are being established. The entire Southern Sudan population is keenly looking to see the dividends of this peace.

Southern Sudan has an estimated population of 9.7 million², with one of the poorest indicators of maternal health in the world; antenatal care coverage stands at 16%, Contraceptive Prevalence Rate at <1% and only 5% of births are attended by skilled health staff³. Maternal Mortality Ratio (MMR) is therefore very high, estimated to be around 1,700 deaths per 100,000 live births⁴, the fifth highest MMR globally⁵. HIV/AIDS prevalence is also rising especially with the current influx of people occasioned by the CPA.

Given the history of wars, the health infrastructure is very weak and access to health facilities extremely limited. The few health facilities have very limited functional capacity. The few health facilities are largely serviced by NGOs, but the fledgling government is beginning to make inroads to take more control. The Health network, with less than 20 mainly small hospitals (depending on the definition of “hospital”), about 100 PHC Centres and 550 very basic PHC Units, is slim and cover only a small proportion of the population. The distribution of facilities is skewed more in favour of the urban than the rural and more south-south than the northern parts of South Sudan, and services are not evenly distributed throughout the region⁶.

The lack of basic emergency obstetric services has had profound effect on maternal health and pregnancy outcomes. This scenario is compounded by absence of a referral network even where the available health personnel would know how to intervene. Not surprisingly, this has led to a very high maternal mortality ratio. Consequently, those

² UNOCHA, Starbase, April 2004.

³ New Sudan Center for Statistics and Evaluation, Towards A Baseline: Best estimates of social indicators for Southern Sudan, UNICEF, May 2004. Note: Special attention should be paid to the definition of skilled health staff and their role in deliveries.

⁴ New Sudan Center for Statistics and Evaluation, Towards A Baseline: Best estimates of social indicators for Southern Sudan, UNICEF, May 2004.

⁵ WHO & UNICEF & UNFPA: Maternal Mortality Estimates in the Year 2000, December 2003.

⁶ UNICEF, Overview of the Health Situation in Southern Sudan, 2003.

mothers that survive end up with very severe morbidity such as vesico-vaginal fistula, recto-vaginal fistula, foot drop etc.

There is limited data on the extent of the problem but reports abound of large numbers of women who have developed VVF reporting to health facilities. Many of these hospitals are run by NGOs and there is credible reason to believe that this is true. These reports have been further corroborated by outcomes of discussions with health authorities in neighbouring Uganda and Kenya that have fistula repair programmes, that a number of patients repaired originate from within Southern Sudan.

The establishment of UNFPA South Sudan Office was initiated in 2005 but the full-functioning of the office only commenced in January 2006. Supported by different sources of funds (i.e., the Netherlands Embassy, the Swedish Embassy and the Common Humanitarian Funds), UNFPA's reproductive health subprogram is focusing on contributing to the reduction of maternal mortality and morbidity through a community midwifery program which will soon start, a fistula program; as part of UNFPA's worldwide campaign to end fistula which is also to build into an EmOC training, provision of Reproductive Health kits and other equipments and supplies to service providers in the public and non-profit sectors, each with an element to sustainably build the institutional and human resource capacity of the public health workforce in South Sudan.

Juba Teaching Hospital as the main hospital in South Sudan with the highest number of patients and staff and also based on the needs assessment done at the beginning was selected as the place for the first repair training. The fact that many roads converge here, Juba has an airport, is in the seat of government and the GOSS/MOH is ready to support and ensure the programme is sustained helped in the choice of this site.



The Participants

Four physicians and fifteen nurses had been selected to participate. Three physicians and fourteen nurses participated fully. Two would-be nurse trainers from Khartoum joined on Friday 5th May but were only able to



learn and refresh their limited knowledge about nursing care over the next 3-4 days before returning to Khartoum.

Dr. Horatio from Surgery department, Dr. Gamal from Obstetrics department and Dr Abdulmuiz, an house physician, eager to learn but understandably weak in basic surgical techniques, were trained. Drs. Horatio and Gamal had practiced successfully over more than 10 years with no opportunity for update in contemporary surgical skills and options. Fourteen nurses were selected from various sections of the hospital and would be released to work in the fistula unit as and when their services are required. All had practiced for over 8 years but had never nursed a fistula patient. Only 3 of the nurses previously knew or had seen of a person living with fistula.

I must salute the resolve of the three physicians and the enthusiasm and devotion of the nurses.

The Training

It was obvious that the participants never cared for fistula patients in their post basic professional carrier since qualification.

- The training was therefore designed to update relevant basic knowledge and fistula specific theory and skills. The training was made interactive to promote in-depth understanding of the issues, continually engage participants' attention, and overcome possible language challenges (most spoke only Arabic). The training involved didactic presentations, plenary and small group discussions and presentations, home assignments, skills demonstrations and clinical practice.

The following Training Aids were used.

- Background reading
- Power point presentations
- Flip chart on flip chart boards
- Drawings and sketches
- Poster displays
- Improvised models
- Demonstrations and return demonstrations
- Home assignments



Wednesday 3rd May 2006 – Thursday 4th May 2006

The training commenced each day with classroom work by 9.00 a.m. and closed 5.00 p.m. There was a 30 minutes tea break at 11.00 a.m. and one hour lunch break at 1.00 p.m. Timing was made flexible by consensus to allow for detailed deliberations.

Friday 5th May – 18th May 2006

Each day except Sundays, classroom presentations and discussions held from 9.00 am – 10.30 a.m. and theatre sessions afterwards till 5.00 p.m. At 5.00 p.m., post operative clinical review of the patients were done and cases for following day selected, evaluated and prepared for surgery.

Daily routine follow-up of operated cases were conducted by Professor Ojengbede and myself by 8.00 – 10.pm daily to review the clinical state of the patients, ensure prescribed management options were followed and to demonstrate clinical nursing care to the nurse participants on duty,.

Didactic Presentations

The following topics were covered during classroom training.

1. Overview of global trends in maternal health with special focus on Sudan/South Sudan. This included discussion on the causes, intermediate and root determinants of maternal morbidity/mortality in South Sudan
2. Historical background for fistula and fistula management
3. Causes and types of genital fistula with emphasis on obstetric fistula.
4. Prevention and management of obstructed labour including the use of partograph – the partograph was not taught in details here.
5. Initial management of patients with fistula and selection of cases for early repairs. Early repair was however not treated as this would be too advanced at this initial training
6. Medical and social evaluation of patients with fistula
 - History taking in obstetric fistula patients
 - Physical examination of patients with urinary fistula
 - Investigations of fistula patients



- Counseling patients and family members
- Conduct of examination and dye test
- Assessment of patients on admission
- Nursing care of patients
 - Admission procedures
 - Pre-operative counseling
 - Post repair counseling
- Preoperative preparation
- Post operative instruction after fistula repair
- Elements of successful management of obstetric fistula
- Instruction on discharge and follow-up care
- Surgical repair of obstetric fistula
 - Identification and assessment of fistula.
 - criteria for classification of fistula as simple and complicated
 - tissue plane dissection to separate bladder from vagina
 - Step by step repair of bladder and then vagina.
 - bladder drainage technique
- Use of flaps and grafts in fistula repair
- Abdominal repair of fistula
- Ureteric repair surgeries
- Repair of Recto vaginal fistula



Practical training session

Theatre training was conducted with emphasis on skills development. The physicians observed and then assisted with cases so as to respond to individual needs. After assisting 3 cases, they were assisted to repair simple cases successfully.

The clinical practice included

- Patients clerkship and evaluation
- Pre operative examination and dye test
- Investigation
- Pre and Post repair counseling
- Theatre operations
- Post operative medical and nursing care
- Surgical follow-up care.



Patients treated during the period of consultancy

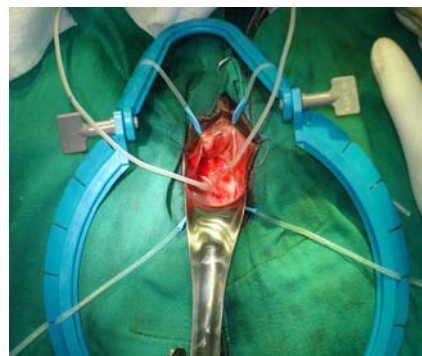
During the period 4th – 18th May 2006, a total of 21 patients with fistula were seen and evaluated. Seventeen of these patients were repaired between 5th and 16th May 2006. The last 4 patients reported at Juba Teaching Hospital on 17th May and so they were assessed but could not be repaired before the departure of the trainer on 18th May.

In addition there were requests for referrals of cases from women groups in Juba and practicing physicians including gynecologists from neighboring towns and states.

Profile of Patients

Patients came from both far and near including as far as from Khartoum!

All the patients developed the fistula following prolonged obstructed labour. The average age was 27 years (17 - 40) parity 2 (1-8). Thirteen (77%) sustained injury during the first birth. The average duration of living with fistula is 7.5 years (1-22 years).



Three of the 17 treated patients had combined vesicovaginal and rectovaginal fistula. Two of the 3 RVFs are complicated while 13 of the 17 VVFs are classified as complicated. Four patients had previous failed repair. One patient in addition to VVF had rectal prolapse which was repaired.

All the cases including combined VVF/RVF cases were repaired at the same surgery.

Ward rounds were conducted every morning before the days teaching and after each day's surgical session. These rounds involved all the participants who were encouraged to contribute to discussions on management of each patient's needs and emerging clinical scenarios.

On 17th May, a grand ward round was conducted to review the progress of each patient for whom the following landmarks were determined to aid clinical management even after the departure of the master trainer.

- Date of commencement of bladder training
- Date of catheter removal
- Possible reasons for EUA, Dye Test evaluation
- Probable date of discharge
- Follow up care and appointments.



Counselling.

Each woman was counseled with the spouse where available prior to surgery, during her recovery in the post-operative wards and on discharge. Her records were carefully reviewed with her/her spouse and findings including those at operation explained.

Bladder training was carried out by the nurses who were supervised by the doctors with advice from the UNFPA RH Coordinator.

Small Skill work shop

One week after the last operation was performed following initial discussions with the German Development Service (DED) and the South Sudan Women's groups, a small skill acquisition/income-generation workshop was mounted for the post-operative fistula patients. This training lasted three days, was fully participatory and was held at Juba Teaching Hospital. The inputs including the resource person from DED and those from the women's group were counted as their contribution to fistula eradication in South Sudan.

The women learned how to keep records and invest in the business in order to ensure sustainability. At the end of the training each woman was given \$300 USD to start off her own business, which was chosen based on their preferences and by what would be feasible considering the areas where they come from.

DED and several women's organizations, who were there to monitor the performance of the participants also offered advice on possible business activities,

such as selling items like sugar, salt and pepper. At the closing ceremony, certificates were distributed to each participant, as well as an insecticide treated bed net, supplied by the MOH. The women received a check-up only two weeks before the writing of this final report. During this time, UNFPA and JTH staff were able to ask the women about their businesses. Many of the women reported that things were going well for them and were markedly happier due to their improved health and financial status. Another follow-up consisting of bringing the women together to form a small forum where they can discuss their experiences, problems and successes stemming from their business. It is hoped that this forum will allow the women to share information from which they can learn from one another. UNFPA also hopes to use these women as advocates for others with similar problems to come forward for repair and re-integration. The women's groups are monitoring the patients to ensure not only compliance with the instructions but how well they are doing in their business ventures.



Challenges

- No fistula trained nurse facilitator was available for this training. Although this did not diminish the quality of training, it increased the burden and responsibility of the expert trainer. Somehow, it also helped the physicians and nurses to appreciate better the team work needed for successful fistula management.
- No trained fistula repair doctor came for this programme as those from Abbo who had initially expressed interest suddenly turned down our invitation without any good reasons.
- Some of the instruments and materials earlier requested prior to commencement were not available especially aneurysm needles and special fistula suture – extra 2/0 chromic catgut on small thick half circle round bodied needle.
- The general knowledge base and skills of medical staff were not current and many gaps had to be filled from time to time.
- The administration of the hospital deserves more support in staffing and in strengthening of leadership and management capability.

Recommendations

In view of the poor maternal health and RH situation in South Sudan and the achievements of the fistula training activities especially the partnership between the GOSS/MOH, UNFPA, RH working group, Media, Community members, and the management of Juba Teaching Hospital, the following are recommended for consideration.

1. All fistula cases reporting at the Juba Teaching Hospital should be carefully evaluated by the trained personnel and classified as simple or complicated using the set criteria discussed during the training. For avoidance of doubt simple fistula will be those not more than 2 cm in diameter, freely accessible, mid vagina or juxta cervical in position, without involvement of the bladder sphincter mechanism, urethral loss and devoid of fibrosis.
2. The Physicians should jointly repair selected simple cases in turn especially Drs. Horatio and Gamal until such a time they are individually able to repair simple cases with other people assisting. Where there is doubt, the case should be deferred even if the compelling challenge was discovered in theatre prior to commencement of surgery. Dr. Horatio's experience should enable him provide leadership in this regard. Other cases can be pooled and appointed for planned repair or referred.
3. All the nurses should be involved in nursing care of treated cases and provide comprehensive education and counseling of the patients as was taught and practiced during the training period.
4. In view of enormous transportation and other social challenges that fistula patients encounter, training of staff from other states should be made a priority and fistula care centers equitably established at other sites. In this regard, the plan to establish fistula repair centres at Aweil/Wau and Malakal should be fasttracked to alleviate the people's suffering. As agreed, the doctors and nurses will be good resource persons in the trainings to come.
5. Subsequent trainings should run over 5-6 weeks
6. To enhance quality of service, the Physicians particularly Drs. Horatio and Gamal would benefit from advanced training in fistula management by an

established fistula expert and at a Fistula Centre with high turnover such as in Nigeria, Ethiopia, etc. Such advanced training runs from 6 – 10 weeks depending on turnover of patients and the base experience of the trainee. For instance some centres in Nigeria repair about 5 cases daily seven days a week during such training.

7. The larger issue of Safe Motherhood, Reproductive Health and Women Development should be addressed through multi disciplinary and multisectoral approach by setting up an RH Training centre where national trainers – to be produced from a TOT, will then go on to train others in country. Strategies should address the following issues.
 - Rapid expansion of access to emergency obstetric care services through a phased training in Life Saving Skills (LSS) for Midwives, Expanded Life Saving Skills (ELSS) for Physicians and Modified Life Saving Skills (MLSS) for cadres just below nurse-midwives. These will prevent obstructed labour and therefore reduce number of patients with obstetric fistula.
8. Accelerated training of more nurses and Midwives. This should be intensified.
9. Experience and report of evaluation of RH programs from African Countries have lamented the deleterious effect of poor leadership and management skills for RH programs. Many of them conclude that this contributes significantly to failure of programs, projects and interventions such that health and development indices are worsening I therefore strongly recommend training in Strategic Leadership and Management and advocacy for Reproductive Health for those holding critical positions at the Ministries – Federal and States, Districts and key facilities such as the Juba Teaching Hospital.
10. All non-institutional training hitherto referred to above can be implemented through the cascade of training trainers who will now step down the training in country.
11. There is urgent need to strengthen other RH services particularly family planning, HIV/AIDS and reproductive tract cancers (especial cervical cancer).

12. Mechanism for cooperation with other programs in South Sudan and similar equivalent programs in other sub Saharan countries be mainstreamed into the program of assistance of UNFPA to South Sudan. It helps to learn and consider best principles and practices, accelerates program implementation and promotes South-to-South cooperation in saving costs.