Challenges in treating Obstetric Fistula in Afghanistan

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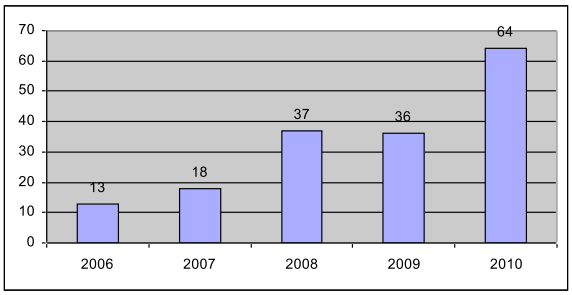
Introduction

The Obstetric Fistula (OF) exists because the health care system fails to provide accessible quality maternal health care.[1] Despite it's devastating impact on the life of women, OF was largely neglected in Afghanistan until Cure International Hospital (CURE) in Kabul started offering OF repairs in 2006. CURE is an international organization based in the USA which has hospitals in 10 developing countries and CURE Kabul is one of these. Its aim is to provide evidence based medicine, and training for medical staff in different areas. This paper is a brief review of all OF work at CURE focusing on results as a function of time, complexity of disease and available expertise at the time of operation, identifying key challenges.

Methodology and results

We reviewed all the cases who presented to CURE for assessment (Figure 1) and then retrospectively reviewed the charts of 109 consecutive OF patients operated on from January 2006 through to June 2010. Ten women had recto-vaginal fistulas (RVF's). The remaining 99 women had vesicovaginal fistulas (VVF's) – some of which involved the ureter (5 cases), urethra (4 cases), and rectum (5 cases). Eight OFs were operated on by a senior surgeon in 2006 before formal training of staff. The remaining 84 OF cases were done from 2007 by two Afghanistan OB/GYN surgeons who had received training at Addis Ababa Fistula Hospital (AAFH) in Ethiopia. A visiting senior surgeon attended 16 of these 84 cases, all of which were complex fistulas involving the urethra or ureter.

Figure 1: Total OF cases seen at CURE 2006 -2010 (both operated and non operated)



Complete continence by year from 2006 through 2010 was achieved in 38%, 78%, 73%, 52%, and 88% of cases respectively. This equates to 76 of 109 OF patients (70%) leaving CURE completely continent. (Table 1) Nineteen women had had 35 prior attempted repairs between them, the majority of them (16 cases) in hospitals in Afghanistan other than CURE and some of them in neighboring countries. The small percentage of redo cases done at CURE were for complex OF involving the urethra or ureter or with severe scarring. A significant number of operative failures occurred in this re-operated group with 12 out of 19 (63%) of these cases failing. Also 8 out of the 24 (33%) of cases performed with and 20 out of the 68 (29%) cases performed without a senior surgeon resulted in failure to achieve continence. Five failures (5 out of 13) occurred in 2006 before operating room and nursing staff were formally trained. In addition two urethral, one ureteral and one rectal repair failed.

Table 1: Training

	2006	*2007*	*2008*	*2009*	*2010*
Training (weeks)*	0	12	20	16	23
Cases operated	8	9	30	21	41
Success (%)**	38	78	73	52	88

***Training at AAFH for all nurses and doctors working at CURE Number of weeks cumulative.**

**** Success is defined as completely dry (continent).**

Challenges

Our results highlight there are a variety of obstacles to setting up a OF treatment center in a developing country such as Afghanistan. And these are mainly centred around the surgical repair.

A lack of experienced surgeons, and theatre staff, case complexity and redo surgery all negatively impact results. Firstly, dealing with a wide variety of complex cases while developing our own expertise is a big problem. There is not just the bladder to repair but also at times the rectum, urethra and the ureters etc. These complex fistula are often very common in the developing world and needs high expertise if the woman is to be continent again.[2]

The problem is there are patient and health professionals' misunderstandings about OF. With many of our patients who have had previous repairs thinking all cases are the same and going to any local doctor for repair who might not be skilled and thus cause a lot of damage which will be heard to fix later even with an experienced doctor. This is significant as it is well known that the first repair offers the best chance of success.[3] Then there is the fact that local doctors able to fix simple cases are pressured to try more difficult ones beyond their means as the patients who do show up for treatment often have unrealistic expectations and place further burden on a new system that is struggling to establish itself. As when the repair fails this then causes further misconceptions about OF repair for other new patients who may stop coming forward for help because they believe it is an incurable condition. Especially as a new centre such as ours is seen as able to perform miracles and is blamed when it cannot deliver success.

To overcome this there has been improved outreach efforts by CURE since October 2009. Eight provinces have been visited and over 1440 healthcare workers trained about the cause of OF and that its treatment including surgery, hospital accommodation, and transportation to CURE is free. This is through various media including TV and radio advertising and brochures. In addition over 200 healthcare workers from 20 provinces have received one month of training at CURE. This will hopefully bring the number of re-operated cases significantly down and combined with an improvement of the quality of repair we can obtain patients trust.

Improved quality of repair means then attracting and retaining well-trained surgeons, nurses and anesthetists which poses difficulties, as there is a significant degree of brain drain. With well-trained workers having many opportunities to take higher paying jobs with USAID, the US government or some other agency that can pay much more than a non-profit NGO. It is clear from our results (Table) that training equates with success of the procedure but is this cost effective if staff will take those skills elsewhere? As of August 2010, all four staff trained in 2007 at AAFH are still working at CURE though one nurse recently left. Methods to retain staff used at CURE include good salaries and ongoing professional development like attending conferences such as the International Society of Obstetric Fistula Surgeons (ISOFS). And offering an honest and fair working environment where career advancement is based on what you can do, not on who you know. We also make continuous professional development mandatory; the aim being to develop a cadre of expert national surgeons to be able to deal with all complicated birth injuries.

Despite these efforts the importance of outside training cannot be overemphasized. Apart from basic and advanced training of national surgeons use of external experts support helped us to overcome the challenge regarding dealing with complex cases. In the beginning years I was trying to find someone to help us in more complex cases. After a lot of searching I finally succeeded in finding short term visiting known senior fistula surgeons to come and

help with the complex OF's such as those involving the urethra and the ureteric fistulas. Some of these cases were deemed as untreatable. We are still following this same principle of saving complex cases for the senior visiting surgeons although by now we can cover most of our cases, but still we need help specifically for diversion procedures, and supervision of our urethral and ureteric cases. These experts not only provide much needed services for local patients, but increasingly train local staff in advanced fistula repair as there is no doubt that successful repairs are a function of surgeon experience. A comparison of cases done with and without the visiting surgeon showing this. (Figure 2) In addition the visiting experts were operating on more difficult cases and their level of success also increased over time.\

Finally, the shortage of the necessary equipment such as proper fistula repair instruments, ureteric catheters, a good quality operating table and light source, suture materials and needles etc. also leads to situations where we cannot operate. We are trying to solve these problems by use of donors.

Conclusions

Our results from trying to manage OF demonstrate common difficulties encountered when setting up OF treatment centers in a developing nation such as Afghanistan. Lack of experienced surgeons, and theatre staff, wide and variable case complexity and redo surgery all negatively impact results. Difficult cases must be delayed until necessary expertise is present. It is not because things are difficult that we do not dare, but because we do not dare that things are difficult. Our thinking is big although our starting is small.

References

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Figure 2: Outcome of number of cases operated on by junior surgeons (JS) versus senior surgeons (SS)