national vvf project nigeria

evaluation report X

1992-1996

reprint

Babbar Ruga Fistula Hospital
KATSINA

and

Laure Fistula Center
KANO

and

Jummai Fistula Center
SOKOTO

and

Centre Hospitalier Departemental
MARADI

by

Kees WAALDIJK

reprint

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MARADI

by

kees waaldijk MD PhD
chief consultant surgeon

Xth evaluation report
VVF-projects KANO/KATSINA/SOKOTO/MARADI

introduction

The obstetric fistula is a major public health problem for which a solution has not yet been found.

It has a tremendous impact upon the patients and the society because the society is ostracizing these unfortunate (mostly young) women depriving them from their right on a "normal" life within their own community.

At the moment there are some 1.5 to 2 million VVF-patients in Africa only, living as outcasts with a bleak outlook to the future as where should they go for treatment??

Since Januari 1984, when the first VVF-patients was operated in KATSINA, a VVF/RVF-repair/training service has been established in Northern Nigeria in KANO, KATSINA and SOKOTO whilst expansion of the programme to other states is already in progress.

Also in Southern Republique du Niger a VVF-center has been set up in MARADI as part of international expansion.

The consultant is under a 5-year contract with the Federal Government of Nigeria with the assignment to train Nigerian doctors in the noble art of VVF/RVF-surgery.

The day-to day running of the centers is being taken care of by the respective State Governments.

We work in close cooperation with the National Task Force on VesicoVaginal Fistula (NTVVF) and the Grassroots Health Organization of Nigeria (GHON) who sponsor the trainees by giving them an allowance. Creation of (public) awareness is one of their major credits.

However, the actual management, planning, writing of curriculum, preparing of teaching materials, documentation and execution of the programme is done by the consultant.

External funding is provided by several Dutch NGOs of which the SK Foundation in combination with the TTT Foundation are the most important.

It cannot be stressed enough that we are running a public health programme which by its nature is a surgical programme: **public health surgery**.
This means that we are trying to reach as many patients as possible and to bring the service near to the patients. Our main aim is to have an impact upon an almost hopeless situation.
Prevention will remain a utopia.

This is an end-evaluation of the programme during the 5-year contract from 1992 thru 1996. Another 5-year contract will be discussed with the Federal Government of Nigeria.

long-term objectives

To establish a lasting VVF-service with ultimately the total eradication of the obstetric fistula.

lasting VVF-service

In KANO and KATSINA a VVF-repair service with training of doctors and nurses has been established. In SOKOTO we are consolidating the service.

Dr Ann WARD is doing a fine job in Akwa Ibom State; the same applies to Dr Jonathan KARSHIMA who is working in Plateau State.

Those centers are capable of dealing with VVF as a public health problem within these 5 states.

However, since 1996 there are 37 states in the whole federation of Nigeria, so centers have to be set up in 32 more states to have an overall covering of the service within Nigeria.

In 21 states doctors have been trained in the (surgical) management of VVF and RVF under our programme but funds/interest are lacking.

During 1997 expansion has been planned to Kaduna State, Jigawa State and Kebbi State. Arrangements have been made already to start as soon as possible.

As part of a bilateral agreement also a VVF-repair service has been started in neighboring Republiqe du Niger in MARADI.

prevention

There is no relation to tribe, religion, culture, early marriage or anything else, except for **early intervention by CS within 3 hours**.

The obstetric fistula will disappear if **any** obstructed labor is relieved in time, i.e. by CS within 3 hours, **whatever the cause**!

Considering the population explosion and the deterioration of health services (both are moving in the **opposite** direction), the incidence/prevalence of obstetric fistulas will increase during at least **fifty years coming** throughout Africa.

All the people speaking about banning of early marriage have to realize the lesson learned from history: The obstetric fistula has disappered from the industrialized world only by **the establishment of a network of functioning obstetric units, and not by banning early marriage**.

Therefore we should not waste our efforts on a political item, but should concentrate on doing the only right thing, viz. setting up proper antenatal and obstetric care, i.e. **a network of 75,000 functioning obstetric clinics thoughout Africa!!**

short-term objectives

To further upgrade/develop the Babbar Ruga Fistula Hospital in KATSINA and Laure Fistula Center in KANO into (inter)national VVF-training centers, and to start new VVF-repair centers.

KATSINA

facilities

Babbar Ruga General Hospital consists of **three units**: a **leprosy unit of 46 beds,** a **tuberculosis unit of 60 beds** and a **fistula unit of 225 beds** making a **total of 331 beds**.

There are no X-ray facilities whilst the laboratory is only being used for leprosy/tuberculosis purposes.

The electric power supply by NEPA is relieble.

The **fistula unit** contains a 38-bed postoperative ward, a 37-bed preoperative/catheter ward, a total of 150 beds in 3 hostels and a small occupational therapy building. If needed the two wards could be merged into a postoperative unit with 75 beds at any time.

The operation theater has been upgraded together with a separate sterilization room and scrubbing area in 1993. However, the only operating table has to be supported by a piece of iron since the hydraulic system broke down in 1992. Sterilization/autoclaving is on a gas stove.

A PEUGEOT J5 bus has been donated by the Dutch Government in 1994 for running of the hospital.
Since a **clean** water supply was not available, two boreholes were drilled on the compound during 1995 by KTARDA. The Dutch Government mechanized one of them; on the other one a handpump has been mounted.
A PEUGEOT 504 stationwagon has been donated by UNDP in 1996 for the fistula project.
A guesthouse for the Nigerian trainees is under construction which will be finished beginning of 1997.
A high-quality hydraulic operating table is needed.
A regular supply of surgical instruments, suturing materials, spinal anesthesia drugs etc. has been provided by the Kiwani Club in TIEL and by the Wereldwinkel in MAASTRICHT.

capacity
The theoretic capacity of 1,000 operations a year is more than sufficient. The **backlog** of patients has been **cleared**, and new patients are attended to immediately.

international training center:
We are completely set and fit now to train different cadres of doctors/nurses from all over Africa.
For a smooth coordination we would like to liaise with WHO, UNDP, UNFPA and NTFVVF/GHON or any other big (inter)national organization.
The main problem is, we need an International Organization to sponsor the traveling/lodging/feeding of the **international** trainees.
Due to a grant from the SK Foundation we started to build a hostel for the Nigerian trainees in KATSINA; whilst for international trainees there are excellent hotel facilities available.

service
The fistula surgery/training service was started in 1984 and is now well established. The postoperative care has to be improved which can only be done by more discipline.

KANO
facilities
Laure Fistula Center is part of Murtala Muhammad Specialist Hospital, the largest hospital in Kano State. In theory all facilities such as laboratory and X-ray department are available.

Originally there was a 20-bed postoperative ward and an operation theater complex on the hospital compound.
The new Amina SAMBO 20-bed postoperative ward, built by a grant from the Kiwani Club ALPHEN a/d RIJN in 1994, is now in full use contributing to the well-being of the patients and to the smooth functioning of the operation programme.
Together there are **40 beds** available for the **postoperative care**.
The **50-bed Kwalli Hostel** is situated 2 km away outside the hospital in KANO town; it needs a total refurbishing.
A completely renovated operating table has been donated by the Soroptomist Club in LONDON in 1995 and has been installed in the theater.
As NEPA is unreliable a small 7.5 kVA standby generator for the theater is needed to ensure that we can operate at all times. Otherwise the electric autoclave cannot be used for sterilizing.

capacity
The theoretic capacity of 1,000 operations a year is more than sufficient. The **backlog** of patients has been **cleared**, and new patients are attended to immediately.

service
The fistula surgery/training service was started in 1990 and is now well established. There is good discipline of all the staff.

SOKOTO
facilities
Jummai Abdulkarim Fistula Center is part of the Specialist Hospital SOKOTO. In theory all facilities are available.

The fistula complex consists of a 20-bed postoperative ward, a 10-bed hostel and two beautiful operation theaters.
However, the equipment of the operation theater is below any standard, and the staff needs proper training.
A high-quality hydraulic operating table is **urgently** needed for the benefit of the surgeon and the patients.

capacity
The theoretic capacity of 400-500 operations a year seems to be sufficient. However, the hostel has to be extended to 30-50 beds.

service
The service was started in 1994 and needs upgrading.
Since the creation of Zamfara State out of Sokoto State there are no longer trained VVF-surgeons in SOKOTO, since 2 moved abroad and another 3 moved to Zamfara State.
The first priority is to train another (deputy) surgeon to take care of the day-to-day well-being of the patients.
Since a **fistularium** is the last thing needed in a public health programme, all the patients who for years were occupying beds have been discharged so now we have room for new patients in need of surgery.

In all centers KANO and KATSINA and SOKOTO there is an urgent need for one hydraulic high-quality operating table; so three in total

JOS
As part of a closer cooperation Dr Jonathan KARSHIMA attended a 2-week in-service training accompanying the consultant in KATSINA/KANO. From time to time the consultant will visit the Evangel Hospital in JOS for further discussions and some surgery if needed. Next year Dr J KARSHIMA will visit the project again in KATSINA/KANO for another 2-week in-service training.

BIRNIN KEBBI
After discussions with Dr Hassan WARA, on his trip to SOKOTO the consultant will visit the VVF-Center in BIRNIN KEBBI in Kebbi State as well on a regular base to help with surgery, management and on the job training starting February 1997.

ZARIA
Arrangements are being made to start a VVF-service in Kofar Gaya Hospital in the beginning of 1997 in ZARIA in Kaduna State.
Cooperation with the Amadu Bello University has been discussed sothat the senior registrars in obstetrics/gynecology will have some exposure to the obstetric fistula related problems and to VVF-surgery.

HADEJIA
Since Dr Said AHMED came back from Russia after finishing his specialization in obstetrics/gynecology, discussions have been finalized to extend the VVF-service to HADEJIA in Jigawa State during 1997.

GUSAU
As soon as Zamfara State is stabilized we shall start discussions to start our programme there since 3 trained doctors are already available. It will be sometime during 1998.

République du Niger
MARADI
The gynecologic department within the Centre Departemental Hospitalier in MARADI is being utilized for the fistula work.
The service was started in January 1996, and we are satisfied with the output in terms of surgery and training.
Every fortnight on Friday the surgical team leaves early in the morning and returns in the evening at KATSINA.
Two nurses were trained, and beginning of next year the surgeon will attend a 2-week training course in KATSINA.

further expansion throughout Africa
It would be a pity if all the expertise gained sofar in (Northern) Nigeria would not be made available to the rest of Africa.
This could be achieved by organizing 2-week **workshops** (not talkshops!) in the respective countries, at least to create the awareness and to show what can be done under primitive circumstances.
The consultant surgeon has to change more from surgery to consultancy and to concentrate more on training/travelling from one place to the other to have an impact upon VVF as an all-Africa public health problem.
After finishing his new contract in some 5 years, when the service has been stabilized in (Northern) Nigeria, the consultant is planning to set up VVF-repair/training centers in the other countries of (West) Africa by staying there 2 months to start it up and coming back once a year for evaluation of the project.
However, as all countries have a different culture/health structure it has to be a service especially designed for that specific country.
During the coming 5 years already **interested** doctors (so not the usual ones who "study" from grant to grant) could be trained and some basic inventory studies could be performed.
Republique du Niger seems to be a good starting point especially since it is a francophone country.
The real problem is: which organization/foundation/government is able and willing to finance an all-Africa obstetric fistula project??

activities

postgraduate training (see Annex I)
The training programme poses an enormous stress, as every quarter year some 3-4 new doctors are coming who have to be trained from scrap, even in basic surgical/anesthetic technics.
Also this training slows down the VVF-repair programme, as it takes fairly long for the trainees to master the history taking, vaginal examination, spinal anesthesia, surgery, postoperative care, counseling etc., and it **all takes time**.
Still it is of utmost importance to continue, as this information/expertise has to be brought to the places where it is needed.

Actually, all the residents in obstetrics/gynecology throughout Africa need ample exposure to the VVF-problem, and this should be part of their curriculum.
After many years of intensive training all types of health personnel in the management of VVF/RVF, we are now ready to to expand our services to other countries as the problem is all over Africa with 1.5-2 million VVF-patients waiting for surgery.

general doctors/senior registrars/deputy surgeons/visiting consultants
Sofar, a total of **79 doctors** have been trained or attended our programmes: 42 doctors with at least 3-year surgical experience, 15 senior registrars in obstetrics/gynecology, 10 consultant surgeons/gynecologists, 10 deputy surgeons and 2 senior registrars in anesthesia.

deputy surgeons
It is only by their dedicated efforts that we are able to provide a proper service. The turnover is high as they are all looking forward to improve their position in society which can only be achieved by further training.

(theater) nurses
A total of **66** nurses from all over the Federation of Nigeria attended and completed the course(s); as well as **2** nurses from Republique du Niger.

training/teaching materials
A curriculum has been written together with several handouts including the short notes, a scientific thesis and a step-by-step surgical manual (see Annexes).

surgery (see Annex II)

During 1996 a total of 1,141 VVF/RVF-repairs were performed: in KANO 311 VVF-repairs and 37 RVF-repairs, in KATSINA 562 VVF-repairs and 60 RVF-repairs and in SOKOTO 98 VVF-repairs and 5 RVF-repairs whilst in MARADI 66 VVF-repairs and 2 RVF-repairs.
During the last 5 years **an average of 1,050 VVF/RVF-repairs a year** could be performed.
Though we are very proud of this achievement, it is **not even up to 1% of what is really needed** considering the 1.5-2 million patients who are waiting desperately for an operation.
Since the beginning of the project in 1984, a **grand total of 8,196 VVF/RVF-repairs and related operations** have been performed.

research

generally
Almost all problems related to VVF-surgery have been solved except postoperative urge incontinence due to detrusor instability.
The intention has been and still is: **make complicated things simple, effective, feasible, safe and payable under primitive circumstances!**, and we are proud to have achieved quite some success.
However, it seems that 2-3 out of 1,000 fistula patients are not operable under our conditions right from the beginning. They present with extensive fistula, subtotal bladder loss, narrow pubic angle and severe funnel-shape vagina stenosis. They need extensive reconstructive surgery, and unfortunately for these patients, they fall outside our basic **public health surgery** programme.

Still their suffering prompted us to undertake some very unorthodox surgery, surprisingly with good results; but only if the distal urethra is intact over at least 1.5 cm. This brings the number of "inoperable" patients down to 1-2 per thousand.

VVF-surgery

classification

A **simple** surgical classification has been developed with implications to operation technique and prognosis.

route of operation

Exclusively the vagina.

position on the operation table

Exclusively the exagerated lithotomy position.

circumferential fistulas

Having started already in 1989 with the **circumferential repair**, this seems to be the theoretical and practical solution for these difficult fistulas. The principles are: a. **circumferential dissection** of the bladder from anterior vagina wall/pubic bones/symphysis/anterior abdominal wall, b. **advancement** of the bladder, c. **caudad fixation** of the anteriolateral bladder walls to the symphysis and d. **circumferential end-to-end vesicourethrostomy**.

It is remarkable how easy it can be performed via the **vagina** in the **exaggerated lithotomy position**. Specifically the outcome as to **continence** is far superior than with other techniques.

corner-corner fistulas

It seems a solution has been found for this very difficult type of fistula though they remain troublesome to repair due to **excessive scarring**.

post-repair stress incontinence grade II-III

Vaginal anterior colposuspension whereby the **anterior vagina wall is fixed onto the anterior abdominal wall (without a gap) and the symphysis** has been the standard approach for the last 4-5 years with good results.

Grading of postrepair stress incontinence from **I** (mild urine loss at standing up/cough) to **II** (leaking urine whilst standing/walking) to **III** (continuous leaking urine whilst lying/ sitting/standing/walking)

It cannot be stressed enough that preoperative examination to exclude any sign of detrusore instability is of utmost importance.

Also a dye test with at least 100 ml gentian violet has to be performed to exclude **minute** fistulas which seem to cause stress incontinence as well!

examination under anesthesia (EUA)

If one is in doubt at a normal vaginal examination about the operability it is better for him/her to refer the patient to a real fistula surgeon. There is no shame in referring a patient to someone more experienced.

immediate surgical management; by means of catheter and/or early closure

Our **standard** treatment for patients with a fistula duration of less than 3 months can be recommended to any fistula surgeon.

Why should the obstetric fistula be an exception to **basic surgical principles**?? with far reaching social implications!!

Already some **950 patients** have been treated with a **success rate of almost 95%!**

bulbocavernosus fat pad graft
this is not done anymore since 1994 in thousands of patients with the same results as somehow the sealing off and continence are not related to this procedure.

urethra reconstruction
Everywhere it is recommended to reconstruct the urethra over a catheter but better adaptation is achieved if the urethra is reconstructed first before a catheter is inserted. The width of the neourethra is checked after each suture by a metal sound H8, and if the lumen is too narrow an anterior UV-tomy can be performed.
Many times the anterior vagina wall has to be reconstructed as well, e.g. by skin-mucosa rotation/advancement flap from either the R or the L labia. This full-thickness vascularized flap gives a good covering of the neourethra, and also improves the width/depth of a traumatized vagina.

micturition under supervision
One of the worst things is when patients with a VVF or post-repair incontinence stop drinking. Because then the chances are high that they develop a chronic cystitis (with eventually shrunken bladder!) and/or bladder stone. Therefore they have to be retrained in drinking abundantly fluids to break through this vicious circle! Telling them is not enough so they have to be instructed under supervision to drink plenty and to pass urine frequently. Some 20% of the patients with severe incontinence do respond favourably to this programme once they understand its meaning.

RVF-surgery
Since serafit (a polyglycolic acid) was used instead of chromic catgut as suturing material, the success rate went up to over 85%.
In many patients a combined abdominovaginal approach seems to be indicated but poor postoperative nursing care does not allow any abdominal procedure.

classification
A **simple** surgical classification is being developed; but things are not so straightforward as in VVF.

colostomy
Though indicated in many instances, this is not practiced simply because of poor nursing care.

sphincter ani rupture
The technique for sphincter ani rupture (with or without rectum trauma) has been simplified to a **mini-invasive procedure** with excellent results.

RVF-repair
Several techniques have been simplified with good results.

suturing materials
Serafit is definitely superior to chromic catgut, but it is too expensive to use it routinely. Therefore we use it only on special indication: RVF-repair, difficult fixation of the bladder onto symphysis, corner-corner fistula and vaginal anterior colposuspension in stress incontinence. In all these instances the **success rate improved by some 10%**.

yankan gishiri fistula
Miss Sandra BOER from the University of AMSTERDAM conducted anthropologic research on this highly interesting cultural phenomenon in a society where female circumcision is **not** practiced.

spinal anesthesia
Dr Said BABAYO conducted a study in 100 consecutive patients to finish his research project to become a consultant anesthetist.

database
The epidemiologic base line data have been prepared for the first consecutive **2,500** patients (see Annexes).

scientific articles/papers
Several of the research projects have been finalized into scientific papers or lectures (see Annexes)

external funds
It is only due to a grant from the SK Foundation in combination with the TTT Foundation that we are able to travel from KATSINA to KANO/SOKOTO/MARADI and back to KATSINA and that we can provide for things like spinal anesthetic agents, suturing material, needles, scalpels, gauze etc. Also the Wereldwinkel in MAASTRICHT is helping out.
The SK Foundation has even extended their help to a more structural aid.

VVF-tourism
It seems several groups in Europe and the USA are using this project to get grants from sponsoring organizations; they even claim (part of) our project as their own (Elkins TE & Wall LL. J Pelv Surg, July 1996).
However, **we are not involved in these proposals!**
To break through the naivity of organizations, editors and readers to believe that people living 10,000-15,000 km away in a full-time job at home are able to execute such a programme, see Annexes.

conclusion
For Kano State and Katsina State a functioning VVF-service has been established including a training programme for doctors and nurses from all over the Federation of Nigeria.
The 3rd center in Northern Nigeria is in Sokoto State but it needs a lot of upgrading whilst in Plateau State Dr J KARSHIMA is running a fine center.
In Southern Nigeria Dr Ann WARD is doing an excellent job in Akwa Ibom State.
Time has come now to expand the programme, first to the other 32 States of (Northern) Nigeria where there is no VVF-service yet and then to the rest of (West) Africa.
Kaduna State, Kebbi State, Zamfara State and Jigawa State are the next targets.
Hopefully, MARADI in Republique du Niger will be the start of an international programme.
Gradually the consultant has to change from a consultant **surgeon** to a **consultant** surgeon traveling all over Africa.
Project documents have been prepared for the next 5 years (see Annexes).

P.S.
what about the rest of the 1,5-2 million VVF-patients in Africa? and .....
which organization/foundation/government is willing to finance the project?

an International Obstetric Fistula Foundation is long overdue!!!

kees waaldijk MD PhD
chief consultant surgeon

list of trainees

present deputy surgeons

Dr Immam AMIR	Laure Fistula Center, KANO
Dr Jabir MOHAMMED	Babbar Ruga Fistula Hospital, KATSINA

past deputy surgeons

Dr Yusha'u ARMIYA'U	Babbar Ruga Fistula Hospital, KATSINA
Dr Shehu BALA	
Dr Aminu SAFANA	
Dr Isah Ibrahin SHAFI'I	
Dr Idris S ABUBAKAR	Laure Fistula Center, KANO
Dr Said AHMED	
Dr Iliyasu ZUBAIRU	
Dr Bello Samaila CHAFE	Jummai Fistula Center, SOKOTO

general doctors with at least 3 yr surgical experience

Dr Garba Mairiga ABDULKARIM	Borno State
Dr Umar Faruk ABDULMAJID	Katsina State
Dr Ibrahim ABDULWAHAB	Niger State
Dr Idris S. ABUBAKAR	Kano State
Dr Abdu ADO	Katsina State
Dr Mohammed I AHMAD	Jigawa State
Dr Said AHMED	Jigawa State
Dr Immam AMIR	Kano State
Dr Ebenezer APAKE	Taraba State
Dr Yusha'u ARMIYA'U	Katsina State
Dr Shehu BALA	Katsina State
Dr Bello Samaila CHAFE	Zamfara State
Dr Umaru DIKKO	Kano State
Dr Gyang DANTONG	Plateau State
Dr Bello I DOGONDAJI	Sokoto State
Dr James O. FAGBAYI	Kwara State
Dr Gabriel HARUNA	Kaduna State
Dr Kabir Aliyu IBRAHIM	Jigawa State
Dr Saidu A. IBRAHIM	Jigawa State
Dr Haliru IDRIS	Katsina State
Dr Sa'ad IDRIS	Zamfara State
Dr Zubairu ILIYASU	Adamawa State
Dr Benedict ISHAKU	Plateau State
Dr Momoh Omuya KADIR	Kogi State
Dr Hassan LADAN	Kebbi State
Dr Sabi'u LIADI	Katsina State
Dr Ado Kado MA'ARUF	Katsina State
Dr (Mrs) Linda MAMMAN	Adamawa State
Dr Umaru Mohammed MARU	Zamfara State
Dr Bako Abubakar MOHAMMED	Bauchi State
Dr Jabir MOHAMMED	Katsina State
Dr Gamaliel Chris MONDAY	Plateau State
Dr Ibrahim MUHAMMAD	Jigawa State
Dr Dunawatuwa A.M. MUNA	Borno State
Dr Yusuf Baba ONIMISI	Kano State
Dr Yusuf SAKA	Kwara State
Dr Aminu SAFANA	Katsina State
Dr Isah Ibrahim SHAFI'I	Kebbi State
Dr Aliyu SHETTIMA	Borno State

Dr (Mrs) Yalwa USMAN	Kano State
Dr Aqsom WARIGON	Adamawa State
Dr Munkaila YUSUF	Kano State
senior registrars in obstetrics/gynecology	
Dr Yomi AJAYI	IBADAN
Dr Francis AMAECHI	ENUGU
Dr Nosa AMIENGHEME	ILE-IFE
Dr Lydia AUDU	SOKOTO
Dr Fatima BUNZA	SOKOTO
Dr Ini ENANG	ZARIA
Dr Deborah HAGGAI	KADUNA
Dr Nestor INIMGBA	PORT HARCOURT
Dr Jesse Yafi OBED	MAIDUGURI
Dr Nworah OBIECHINA	ENUGU
Dr John OKOYE	ENUGU
Dr Benneth ONWUZURIKE	ENUGU
Dr Mansur Suleiman SADIQ	KANO
Dr Dapo SOTILOYE	ILORIN
Dr Emmanuel UDOEYOP	JOS
Dr (Mrs) Marhyya ZAYYAN	KADUNA
senior registrars in anesthesia	
Dr Saidu BABAYO	Bauchi State
Dr Abdulmummuni IBRAHIM	Katsina State
visiting consultants	
Prof Dr Shafiq AHMAD	PESHAWAR, Pakistan
Dr Said AHMED	HADEJIA, Nigeria
Dr Frits DRIESSEN	NIJMEGEN, Holland
Prof Dr Jelte DE HAAN	MAASTRICHT, Holland
Dr Vivian HIRDMAN	STOCKHOLM, Sweden
Dr Jonathan KARSHIMA	JOS, Nigeria
Prof Dr Oladosu OJENGBEDE	IBADAN, Nigeria
Dr Thomas J.I.P. RAASSEN	NAIROBI, Kenya
Dr Ruben A. ROSTAN	MASANGA, Sierra Leone
Dr Ulrich WENDEL	BESIGHEIM, Germany
medical anthropologist	
Sandra BOER	AMSTERDAM, Holland
physiotherapists	
Garba M FAGGE	Kano State
nurses	
Mohammed B A ADAMU	Adamawa State
Rauta I BENNETT	Bauchi State
Hauwa D HERIJU	Borno State
Martha F MSHEH'A	
Theresa INUSA	Kaduna State
Hajara S MUSA	
Sara SALEH	
Fatima A UMARU	
Alheri YAKUBU	
Herrietta ABDALLAH	Kano State
Florence AJAYI	
Esther AUDU	
Hauwa BELLO	
Sherifatu A JIMOH	
Ramatu DAGACHI	
Amina KABIR	
Kutaduku B MARAMA	

Hadiza MOHAMMED	
Mairo A MOHAMMED	
Mabel A OBAYEMI	
Comfort OYINLOYE	
Rabi RABI'U	
Amina UMARU	
Habiba A USMAN	
Adetutu S AJAGUN	Katsina State
Magajiya ALIYU	
Taibat AMINU	
Hauwa GARBA	
Halima IBRAHIM	
Kabir K LAWAL	
Ladi H MOHAMMED	
Halima I NOCK	
Saratu S SALEH	
Alia USMAN	
Aishatu M ANARUWA	Kebbi State
Aishatu SAMBAWA	
Kulu A SHAMAKI	
Leah T AMGUTI	Kogi State
Hajara JOSEPH	Niger State
Dorcas NATHANIEL	
Hauwa TAUHID	
Rhoda T AGANA	Plateau State
Victoria S HARRI	
Lami PAN	
Esther ADAMU	Sokoto State
Beatrice AKINMADE	
Elizabeth Y GAJE	Yobe State
operation theater nurses	
Mohammed B A ADAMU	Adamawa State
Dahiru HALIRU	Kaduna State
Florence AJAYI	Kano State
Mairo ALIYU	
Ramatu DAGACHI	
Hadiza ISAH	
Amina KABIR	
Hadiza MOHAMMED	
Rabi RABI'U	
Maijiddah SAIDU	
Adetutu S AJAGUN	Katsina State
Taibat AMINU	
Saratu GAMBO	
Mohammed HASHIMU	
Halima IBRAHIM	
Kabir K LAWAL	
Hauwa MAMMAN	
Faruk SAMBO	
Alia USMAN	
nurses/midwives from Republique du Niger	
Zakari AYOUBA	MARADI
Maimouna Saidou BAGNA	

VVF/RVF-repairs in Laure/Babbar Ruga/Jummai Fistula Centers and MARADI

	KANO		KATSINA		SOKOTO		MARADI		
	VVF	RVF	VVF	RVF	VVF	RVF	VVF	RVF	grand total
1984	-	-	83	6	-	-	-	-	89
1985	-	-	196	20	-	-	-	-	216
1986	-	-	260	18	-	-	-	-	278
1987	-	-	318	7	-	-	-	-	325
1988	-	-	353	31	-	-	-	-	384
1989	-	-	464	21	-	-	-	-	485
1990	222	25	416	29	-	-	-	-	692
1991*	248	17	195	4	-	-	-	-	464*
1992	348	27	529	34	-	-	-	-	938
1993	416	35	488	62	-	-	-	-	1,001
1994	373	43	496	45	42	-	-	-	999
1995	373	51	537	51	161	11	-	-	1,184
1996	311	37	562	60	98	5	66	2	1,141
total	2,291	235	4,897	388	301	16	66	2	**8,196**

total VVF-repairs and related operations: **7,555**

total RVF-repairs and related operations: **641**

success rate at **VVF** closure roughly **90%** per operation

success rate at **RVF** closure roughly **85%** per operation

healed by catheter only: **365**

wound infection rate: **< 0.5%**

postoperative mortality rate KANO: **0.5%**

postoperative mortality rate KATSINA: **1%**

overall success rate at closure (after one or more operations): **96-97%**

severe (stress/urge) incontinence rate: **2-3%**

* sabbatical leave consultant for 6 mth

annex Ia

known performance of trainees

Dr Said AHMED	over 800 repairs
Dr Ilyasu ZUBAIRU	over 500 repairs
Dr Yusha'u ARMIYA'U	over 500 repairs
Dr Jabir MOHAMMED	over 300 repairs
Dr Bello Samaila	over 300 repairs
Dr Aminu SAFANA	over 200 repairs
Dr Hassan WARA	over 200 repairs
Dr Idris HALLIRU	over 200 repairs
Dr Idris ABUBAKAR	over 100 repairs

vvf tourism

claiming credit for what is not yours
scientific disinformation

just by chance i came across the following **fake article** about **my training program**

1996 TE Elkins and L Lewis Wall: report of a pilot project on the rapid training of pelvic surgeons in techniques of obstetric vesicovaginal fistula repair in ghana and nigeria. **journal of pelvic surgery 1996 2:182-186**

the article is a **complete fake** for the nigerian part; the only truth is: there was a training program for 9 senior residents during 1992-1993

since I do not like it nor accept it that somebody else claims credit for my work, here are my comments and what really took place

training of 9 senior residents in obstetrics/gynecology in kano/katsina

during the first half of 1992 i am being approached by dr oladosu ojengbede, head of department obstetrics/gynecology at university of ibadan, if i am willing to train senior residents in obstetrics/gynecology in vvf/rvf **within my existing vvf-training program since 1987!!**

i have no objection, especially since i think it is very important that future gynecologists know all about the (obstetric) fistula being a major public health problem in nigeria; the more the better!

the real training starts the second half of 1992 and ends in august 1993

they come in groups of two accompanied by dr ojengbede; between each group there is at least one month pause as this training puts an extra stress upon me and since I have other surgical trainees as well

before i start their training i have an interview with each of them to know their intention and to explain the purpose of my training program; i tell them that they should consider this as an **intensive exposure** to vvf/rvf and explain that they can only perform 1-2 simple repairs themselves, since they must have ample vaginal surgical experience; if they are in need of further surgical training they have to come back later; i give each of them my phd thesis, my short notes/checklist of vvf/rvf and several other papers such as incidence on vvf and prevalence of vvf as presented by me at workshops and meetings of the national task force etc

their training lasts 19-21 working days which start 7.00 hr am and end at 17.30 hr pm.

they accompany me in my car from kano-katsina-kano in the following rhythm: 2 days kano, then 5 days katsina, then 2 days kano etc during a 7-day work week

their training consists of the following: history taking, proper vaginal examination (without anesthesia), surgical classification, catheter treatment, early closure, spinal anesthesia, different surgical technics for the different types of fistulas, postoperative care, early/late postoperative complications and their treatment, dye testing and patient counselling; special attention is given to meticulous documentation, since this is very important for evaluation.

all their training is being done by me **personally under my direct supervision**.

during these 19-21 days they see at least 200 vvf/rvf-patients consisting of new patients and patients coming for follow-up; all these patients are being examined properly; they attend at least some 80-100 vvf/rvf-repairs in which i demonstrate the different technics **extensively**; they perform 1-2 repairs in which i **personally** assist them from the begining to the end; they perform some 25-30 spinal anesthesia procedures; they perform dye testing and are responsible for the postoperative care together with my other surgical trainees

however, prof te elkins and dr l lewis wall are **not** involved in this training **at all**, and have contributed **nothing whatsoever** to my program, **neither** in devising the program, **nor** in writing the curriculum, **nor** in providing the teaching material, **nor** in delivering the actual training, either theoretically or practically, **nor** in funding; actually they do not attend a single one of these training sessions since they are **10,000-15,000 km far away** in a full-time job in the usa

since i am so isolated here in northern nigeria and have no access to the western medical journals i would like to react by asking the following questions in order to break thru not only the **naivety** of editors, peers, referees and readers

is there not a thing like **common sense**

are academic people really so naïve or are they just arrogant

peers, is it: you peer me i peer you

how can anybody who lives and works full time in the usa (2 weeks holiday a year) or europe execute a training program about the surgical management of the obstetric fistula in northern nigeria

how does a person who lives and works full time in the usa or euorpe picks up the expertise since there are no obstetric fistulas in the industrialized world

who is organizing things on ground

what about preparation and follow.up

is it not normal that editors only accept/print if they have written consent by all persons involved

kees waaldijk MD PhD 13th of september 1996

the purpose of developing aid

in january 1994 i am being approached by 2 doctors from an american nongovernmental organization about major participation in a programme to help the obstetric fistula patients; i agree and share all kinds of information with them
then I hear nothing from them until more than 2.5 years later by chance I get hold of a proposal from the same ngo to a large organization amounting to 10,000,000 (ten million) us dollars out of which 60% = 6 million us dollars to be spent on the training of resident doctors in their american university teaching hospital; however, there are no obstetric fistulas in the usa
I am shocked and start wondering about the purpose of developing aid
should we in the industrialized world help the unfortunate people in the developing world or should the obstetric fistula patients now provide funds for several well-paid jobs in a university hospital in the usa
since i am sure this is not the first time and other doctors in the developing world have experienced the same, i would like to present the following scenario

scenario
one becomes interested in the obstetric fistula and starts looking for the target: complete control especially of funds/credit!
however, one is physically 10,000-15,000 km away from where the action is and totally occupied by a full-time job at home
one writes a proposal (combining facts with fiction) to an organization to get funds for a pilot study to provide more information
one starts traveling building up a "network" of so-called experts but very carefully avoids the real experts
one writes is his evaluation report there are millions of VVF-patients and nothing is done about the problem but he himself is willing to change that; in this report one downgrades the real experts and upgrades the others according to the old proven strategy divide and rule!
one makes a report (faking the real situation by twisting the truth with what one thinks is necessary to shine) which is only sent to the funding agency and hidden from everybody else
with this "final report" one approaches other organizations for funding another major project
in the follow-up proposal a large amount of money is asked sothat one is being considered to be serious and to have studied the situation extensively, including the names of experts who have never been asked if they agree
one promises everybody a major part of the funds to gets their cooperation but makes sure nobody gets anything
no research protocols are being made, otherwise later on one cannot manipulate the outcome according to his own intention/wishes
then one starts reporting to the scientific world claiming things to which one has not contributed anything knowing that most experts in the field do not have the time to read or to react in time
very cleverly one mixes the disinformation to such an extent that only the people who are really deeply involved in the care of obstetric fistula women know it is all **fake**
one has achieved **nothing** for the unfortunate patients but **everything** for himself.

kees waaldijk MD PhD
full-time fistula surgeon

15th of September 1996

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