national vvf project nigeria

evaluation report IX

first half 1996

reprint

Babbar Ruga Fistula Hospital
KATSINA

and

Laure Fistula Center
KANO

and

Jummai Fistula Center
SOKOTO

by

Kees WAALDIJK

reprint

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VVF-projects

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IXth evaluation report
VVF-projects KANO/KATSINA/SOKOTO and MARADI

introduction

There is a slow but steady progress with the implementation of our VVF-surgery/training project as **public health surgery**.
It seems the backlog of patients in Kano and Katsina State has been cleared and there are no long waiting lists anymore.
There are some groups in Europe and in the United States of America who are approaching sponsoring organizations with proposals **to obtain grants** using our project as an introduction, or stating that nothing whatsoever is being done about VVF in Northern Nigeria, or even claiming part of our project as their own. However, **we are not involved in these proposals**.

long-term objectives

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

VVF-service

In 5 out of the 31 states in the whole of Nigeria there are functioning VVF repair centers, viz. Akwa Ibom State (run by Dr Ann WARD), Plateau State (run by Dr Jonathan KARSHIMA), Kano State, Katsina State and Sokoto State. So we have a long way to go before there are functioning centers in the 26 more states.

prevention

The establishment of a **network of 75,000 functioning obstetric obstetric units throughout Africa** is a utopia for the moment. However, it is the only solution for VVF as a major public health problem.
The population explosion and deterioration of the health care system are moving in the **opposite** direction.

short-term objectives

KATSINA

End of last year a relation of one of the VVF-patients came with chickenpox resulting in a chickenpox epidemic which lasted up to June 1996!
In January there was an outbreak of cerebrospinal meningitis (as usual during the dry/cold harmattan); it stopped after all the patients/staff were vaccinated.
During June there was an outbreak of serious gastroenteritis throughout the state including Babbar Ruga Hospital. This always happens at the beginning of the raining season. A special Task Force was appointed.

KANO

In one week in January 5 patients fitted some 4-6 days postoperatively but **no** signs of cerebrospinal meningitis were found; then it stopped.
End of June there was an outbreak of "cholera" in the hostel Kwalli!

SOKOTO

As there was no fuel available during the first 4 months of the year, the consultant could only visit the place once. On a previous trip we had to return at two-thirds of the distance because there was not a single drop of petrol available in GUSAU.
There were some difficulties between the deputy surgeon and the management resulting in a degrading of the VVF-service. We shall look into these problems, discuss it with both parties involved and try to get a solution.

The wards are occupied by patients which could be discharged (stress and/or urge incontinence) as they do need surgery but for some reason or the other are there already for **years**! This is the wrong approach as they occupy the beds of any (new) patient in need of operation. As such the efficiency rate of the project is too low in terms of public health surgery.
It is not the intention to provide outcasts with shelter but to **prevent** new outcasts to be added to the number already existing!
The operating table is below any fistula surgery standard, and the consultant has to sit on a **dustbin** to perform the repairs since the table cannot be adjusted in height and in lithotomy position!
It shows strength that despite all these problems still a fair amount of surgery could be performed.

In all centers KANO/KATSINA/SOKOTO there is an urgent need for a hydraulic high-quality operating table; so <u>three</u> in total; six operating tables seem to be <u>not</u> feasible, even these three????

<u>MARADI</u>
Just over the border in Republique du Niger, only 90 km away from Babbar Ruga Hospital, there are quite a number of patients as well. We always thought that these patients were coming to us, but it seems now that only the "**richest of the poorest**" could afford it.
It is another example that the obstetric fistula is a major public health problem throughout Africa.
After initial beaurocratic problems, every fortnight on Friday we go there early in the morning and return early in the evening.

<u>JOS</u>
In June the consultant visited Dr Jonathan KARSHIMA from the Evangel Hospital in JOS to discuss about closer cooperation which is supposed to start in September this year.

<u>activities</u>

<u>training</u> (see Annex I)
During the various courses for the different cadres of doctors, only the basic surgical principles of VVF/RVF-surgery including history taking, preoperative care, catheter treatment, spinal anesthesia, postoperative care, follow-up and counselling can be taught.

general doctors with at least 3 yr surgical experience
Sofar, 15 doctors from 8 different states have been trained for a minimum period of 3 months.

senior registrars in gynecology/obstetrics
A total of 9 senior registrars have had ample exposure during their 3-week programme accompanying the consultant in both centers.

senior registrars in anesthesia
One doctor came forward to be trained in spinal anesthesia and others are encouraged to do the same.

visiting consultants
The 6 consultants came for a 2-week visit to both centers to have a look around and see if they could benefit from our programme which I hope they did.

surgery (see Annex II)
The reliable supply of surgical instruments, spinal anesthetic agents and suturing materials was only possible due to continuous donations by the stichting van Tiel Tot Tropen, the Kiwani Club in TIEL and the Wereldwinkel in MAASTRICHT.

research

generally

VVF-surgery

classification (see Annexes)
The classification based upon the anatomic/physiologic location proved to be very valuable.

route of operation
Which surgeon is contemplating of performing a tonsillectomy through the neck? All the VVF-repairs have been performed through the vagina with the exception of one only, a vesicouterine fistula and the second repair in the consultant's life who is an abdominal/traumatologic surgeon by profession!

position of the patient
Inavariably the (exaggerated) lithotomy position with the legs flexed and abducted and the buttocks far over the end of the operation table.

assistance
Only the surgeon and an instrumentating operation nurse. Two retractors inside the vagina are already a crowd.

instruments
Normal vaginal instruments, including an AUVARD self-retaining speculum, a pair of curved THOREK scissors and a sharp DESCHAMPS aneurysm needle.

suturing materials
Only chromic catgut for the bladder/urethra and supramid for the anterior vagina wall on small needles. No atraumatic suturing materials which actually would be preferred for urethra reconstruction.

immediate surgical management; with catheter and/or early closure
Out of the 302 patients treated during the 17-month period (since started in August 1992), the fistula was closed in 286 (94.7%). Also the continence rate was very good as only 3 (1.9%) out of 156 patients with closed fistula who completed 6 months "postoperatively" complained about and demonstrated severe incontinence.
It has become the standard treatment for any woman with a fistula duration of less than 3 months, and can be recommended to any fistula surgeon.
The latest development is to perform debridement of the necrosis in order to speed up the healing process, so early closure becomes even earlier.
Its main advantage is not only its high success rate as to closure and continence, but especially the prevention of the girl/woman from being ostracized out of her own society.

RVF-surgery

As a colostomy is unacceptable to African patients, all our RVF-surgery is done without it. As an abdominal approach is too risky in our set-up, only the vaginal route is used though it must be said that a combined vaginal/ abdominal procedure in certain types would be preferable.
A lot of research has been done on the RVF-surgery, and slowly but surely the success rate is improving.

Since we started a combination of intravaginal/intrarectal surgery (using PARK retractors) it seems we are on the right way.
Also whenever possible we combine the VVF-repair with a RVF-repair in the same session, with good results.

spinal anesthesia
It is the anesthesia of choice for operations on the lower half of the body as it simple, effective, safe and cheap. No major investment is required.
N.B. the total costs per anesthetic procedure including everything (equipment, drugs, gauze, methylated spirit etc) is not up to one US dollar!

administration/documentation
The time spent on administration/documentation is at least 2-3 times more than the time spent on operating.
It is extremely important that the work is documented properly, otherwise nobody knows what he/she is doing.
The Schumacher-Kramer Foundation in AMSTERDAM made funds available to purchase professional cameras and computers with printer.

database (see Annexes)
Within the coming 2 years all the 400,000 parameters collected sofar will be put into an extensive computerized related dBase programme sothat the various determinators can be analysed.

photography
Already for years, each fistula/operation has been documented by at least 3-5 color photographs/slides, including multiple series of 30-40 slides for the different operation technics; sofar over 20,000 color slides. The trend is to even extend this type of documentation.

video
Some 30 hours of operation technics have been documented by video, but we need a semiprofessional camera sothat these videos can be edited and then multiplicated. Also a documentary of the obstetric fistula is a must.

teaching materials (see Annexes)

The short notes/checklist on VVF has be been updated. The surgical handbook on VVF-surgery will probably published next year.

conclusion
For Kano State and Katsina State a functioning VVF-service has been established including a training programme for doctors from all over Nigeria.
Time has come now to expand the programme, first to the other States of (Northern) Nigeria and then to the rest of (West) Africa.
It would be a pity if all the experience/expertise in VVF-care and training obtained during the last 10 years would not be used.

P.S.
what about the rest of the 1,5-2 million VVF-patients in Africa?

an International Obstetric Fistula Foundation is long overdue!!!

First an awareness campaign has te be started in the industrialized world, then a plan has to be developed (already present in principle since 1989) followed by a fund-raising campaign, and as last step this plan has to be executed under a big organization like the United Nations with continuous monitoring of the activities and results.

kees waaldijk MD PhD
chief consultant surgeon i/c

Babbar Ruga Fistula Hospital
P.O.Box 5
KATSINA

and

Laure Fistula Center
Murtala Muhammed Specialist Hospital
KANO

list of trainees

present deputy surgeons

Dr Idris S ABUBAKAR	Laure Fistula Center, KANO
Dr Jabir MOHAMMED	Babbar Ruga Fistula Hospital, KATSINA
Dr Bello Samaila CHAFE	Jummai Fistula Center, SOKOTO

past deputy surgeons

Dr Yusha'u ARMIYA'U	Babbar Ruga Fistula Hospital, KATSINA
Dr Aminu SAFANA	
Dr Said AHMED	Laure Fistula Center, KANO
Dr Iliyasu ZUBAIRU	

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 Imman AMIR	Kano State
Dr Ebenezer APAKE	Taraba State
Dr Yusha'u ARMIYA'U	Katsina State
Dr Shehu BALA	Katsina State
Dr Bello Samaila CHAFE	Sokoto 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 Saidu A. IBRAHIM	Jigawa State
Dr Sa'ad IDRIS	Sokoto 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	Sokoto 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 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 Frits DRIESSEN	NIJMEGEN, Holland
Prof Dr Jelte DE HAAN	MAASTRICHT, Holland
Dr Vivian HIRDMAN	STOCKHOLM, Sweden
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

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	
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	
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

<u>operation theater nurses</u>

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	

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 first half	160	20	316	32	46	5	35	1	615
total	2,140	218	4,651	360	249	16	35	1	**7,670**

total VVF-repairs and related operations: **7,075**

total RVF-repairs and related operations: **595**

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

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

healed by catheter only: **342**

wound infection rate: **< 0.5%**

postoperative mortality rate KANO: **0.5%**

postoperative mortality rate KATSINA: **0.5-1%**

* sabbatical leave consultant for 6 mth

annex Ia
known performance of trainees

Dr Said AHMED	over 700 repairs
Dr Yusha'u ARMIYA'U	over 600 repairs
Dr Ilyasu ZUBAIRU	over 300 repairs
Dr Bello Samaila	over 300 repairs
Dr Jabir MOHAMMED	over 300 repairs
Dr Aminu SAFANA	over 200 repairs
Dr Hassan WARA	over 200 repairs
Dr Idris ABUBAKAR	over 100 repairs

annual meeting of association of general and private medical practitioners of nigeria

jos

20th of march 1996

VVF-service in (Northern) Nigeria

kees waaldijk MD PhD
chief consultant surgeon

introduction

Nigeria covers an area of almost 1 million sq km and has a population of some 120 million people.

With a life expectancy of 50 years, a perinatal mortality rate of 20%, a maternal mortality rate of 1.5% and an annual population growth of at least 3%, there are some 7 million deliveries a year in the whole federation.

The **incidence of the obstetric** vesicovaginal **fistula** (VVF) has been calculated at a minimum of **1.5-2 per 1,000 deliveries where the mother survives in situations where obstetric care is poor**, irrespective of race, tribe, religion, early marriage etc.

The **incidence in the whole Federation of Nigeria** is then 2% of 7 million being **12,000-15,000 new VVF-patients a year**.

As a maximum of 2,000 patients are being operated successfully each year, there is a huge backlog of patients, each year already over 10,000.

The **prevalence in the whole Federation of Nigeria** can be calculated then at **a minimum of 150,000 VVF-patients in need of surgery**.

This constitutes a **major public health problem** with far reaching social implications as these (mostly young) women/girls are being ostracized from their own community.

There are 4 centers in Nigeria where annually more than 150-200 patients are operated, viz. in Akwa Ibom, Kano, Katsina and Sokoto State. However, these centers are no enough by far, and each of the 31 States needs its own center.

prevention

N.B. early marriage, a hot political item, has nothing to do with the obstetric fistula. Primary health care can only play a role by detecting risk factors antenatally and by immediate referral if obstructed labor develops.

Prevention is solely by **early intervention of obstructed labor by cesarean section within 3 hr** to prevent necrosis.

In the industrialized world the obstetric fistula has disappeared by establishing a network of functioning obstetric care/units, and not by banning early marriage; this exercise took some 50-70 years.

In Northern Nigeria already 1,875 functioning obstetric clinics are needed where an emergency cesarean section can be performed; who is going to pay for this?? **Education and time** will take care of this!

Though ultimately prevention is the solution, it remains a utopia for at least 50 years to come.

The **yankan gishiri fistula**, like female circumcision a cultural phenomenon, could be eradicated by a mass enlightening programme; but it is difficult considering the experience with female circumcision.

Secondary prevention of the patient from going down into an ever-increasing social isolation **is achieved by a successful repair with total spontaneous rehabilitation**.

what has been achieved in (Northern) Nigeria

Three VVF-centers have been established from scrap in Kano, Katsina and Sokoto where far over **7,000 patients have been repaired**:

Laure Fistula Center with 40 postoperative beds, a hostel of 60 beds where theoretically 1,000 repairs could be performed yearly.

Babbar Ruga Fistula hopsital with 38 postoperative beds, a hostel of 150- 200 beds where theoretically 950 repairs could be performed yearly.

Specialist Hospital Sokoto with only 20 postoperative beds and no hostel where theoretically 250-300 repairs could be performed.

In Kano and Katsina **61 doctors and 61 nurses have been trained** in examination, catheterization, spinal anesthesia, classification, surgery, postoperative care, documentation, couseling and management.

Awareness of the VVF-problem **has been created throughout the society** in the whole of the Federation of Nigeria.

what can be done now!

VVF-centers

To establish VVF-centers in each of the 31 states in or near the state capital, where patients can come for surgery/counseling and doctors/nurses for training, also in the preventive aspects.

These centers should be separate units integrated into existing government health services at least until the backlog of patients has been cleared.

It must be possible to expand our existing VVF-service with **one state each year** after careful planning/training.

see also the project document Expansion.

training

VVF should be incorporated into the curriculum of the registrars in obstetrics/gynecology. For this the Society of Obstetricians/Gynecologists of Nigeria has to be involved.

Any gynecologist in the whole of Nigeria should be familiar with the VVF-problem and its management.

see also project document Training.

yankan gishiri

An awareness programme has to be started to inform the public and the traditional health caretakers (wanzami, ungozoma) that this practice is very dangerous and therefore should be abolished.

research

More research is needed into all the aspects of VVF, especially the demographic and epidemiologic parameters, but also into its prevention and into a simple surgical programme.

Simple solutions are the best, but how to find them??

see also project document Research.

Babbar Ruga Fistula Hospital in KATSINA

It should be developed into a WHO-recognized training center for the whole of (West) Africa as the obstetric fistula is an Africa-wide problem.

All the facilities to train doctors/surgeons/nurses how to perform **quality VVF-care under primitive conditions** are available.

All the personnel are highly experienced in the care as well as in training all cadres of health workers.

Good national, international and intercontinental connections are available as well as a high-standard accommodation.

see also project document KATSINA.

Laure Fistula Center in KANO

It should be further developed into a training center for Nigerian doctors/ nurses as well as a research center especially in cooperation with Bayero University.

Another 100-bed hostel is needed since the present one is in very poor hygienic condition and as its capacity is not sufficient.
Good national, international and intercontinental connections are available as well as medium-standard accommodation.
see also project document KANO.

Specialist Hospital in SOKOTO

It should be further developed into a VVF-repair center for Sokoto State; perhaps some research could be done in cooperation with the Usman Danfodio University.
An upgrading of the operating table as well as a 50-bed hostel is urgently needed.
see also project document SOKOTO.

financing

As it is a Nigerian health problem, it has to be solved within the limited financial resources of Nigeria.
The State Governments should take care of the day-to-day running including personnel, equipment etc., and the Federal Government should take care at a different level, e.g. employ the consultant, supply transport, etc.
However, not all can be financed by Nigeria, and that is the stage where a large nongovernmental organization has to come in together with one or more division(s) of the UN family, like WHO, UNDP, UNFPA etc.

the problem with surgeons is that they tend to do too many things at the same time in order to help the patient; however, it is better to concentrate on one thing at a time and make sure it is done properly

as well the trend is to make simple things complicated to impress oneself and others; that is easy

however, the **art of surgery** is to make complicated things simple and to concentrate on the essentials; and that is very difficult

simple solutions are the best; only how to find them?

therefore we are in the continuing process of simplifying our approach according to basic general surgical principles whilst ensuring high quality:
minimum dissection
tension-free closure
minimum amount of sutures
one-layer closure of bladder/urethra
no dye testing
no martius fibrofatty graft
only adaptation of vagina wall
principles of reconstructive surgery

whatever we do it has to make sense

the best rehabilitation is a **successful** repair, so why waste time, energy and money?

primary prevention
is a utopia for at least another century

secondary prevention
the **immediate management** by catheter and/or early closure is my best contribution to the obstetric fistula considering the high success rate at closure and continence **preventing** the woman from becoming an **outcast**

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