

## Levels for facilities-based Services for Fistula Care

#### January 2009

Establishing fistula repair services is complex. Fistula repair is major surgery requiring a high level of surgical skill, even for uncomplicated repairs. Training surgical teams is a necessary, but not sufficient condition, for establishing access to fistula treatment services. Full decentralization of fistula repair services to all sites capable of surgical services is not practical in terms of safe and sustained provision of services, nor is it cost effective or feasible with the resources currently available. It is important, therefore, to partner with local government and site administrations as well as communities to ensure they are fully committed to establishing the environment in which services can effectively be provided continuously. At the same time, it is important to ensure that the service system is capable of responding to identified needs before creating further awareness of service availability.

Fistula surgery usually requires a minimum of three weeks post-operative care in the hospital, in addition to pre-screening and treatment for adjunct conditions, so the capacity to increase the number of surgeries at individual sites is limited by the availability and skill levels of the physicians, the number of operating theaters available for elective procedures (because fistula surgery is almost never an emergency), and the number of beds available to support long-term stays. Many facilities experience supply chain ruptures for items as basic as sutures. Ensuring access for women to quality fistula services is further complicated by the fact that many women are too poor to pay and there are not enough trained providers to handle cases. It is therefore necessary to increase access to quality services in a phased manner.

Fistula Care has developed a framework for a network of sites to facilitate prevention, diagnosis, limited treatment and referral, treatment of simple cases, treatment of complex cases and the establishment of a site or sites capable of providing training. The following is a description of the three levels of facility-based care that we envisage:

#### *Level 1: Diagnosis, limited treatment and referral*<sup>1</sup>

Sites at this level would likely be staffed by surgeons and surgical teams who are at the very beginning of their training in fistula surgery, although it would not be essential for a surgeon to be in training for this level. Over time, as the expertise of surgeons in fistula repair increases, the site would be expected to advance to level 2 and ultimately to level 3. At level 1, the site would be expected to:

- Carry out awareness creation activities for fistula prevention and/or link with community-based organizations to support awareness creation. This may include messages to increase girl's education to the completion of secondary school, delaying early childbearing, FP for delaying, spacing or limiting of pregnancies, men's roles in facilitating women's access to safe delivery, and skilled care for delivery.
- Where services permit, carry out the following additional fistula prevention activities:
  - Provide family planning counseling and methods provision during routine ante-natal care and at discharge or at post-operative follow-up visits for fistula clients
  - ANC to include health education for timely arrival at delivery facility and for signs of obstructed labor, outreach to families/partners for birth planning, including a transport plan
  - Labor and delivery to include active and continuous use of the partograph for safe labor and delivery; referral for emergency services not provided at the site; and where provided, management of obstructed labor (including prophylactic catheterization); and safe operative delivery (forceps, vacuum, c/section.)
- Carry out selected rehabilitation/reintegration activities such as fistula counseling and physical therapies
- Have staff with the skills to assess women with a complaint of incontinence; diagnose and classify fistula for appropriate management and referral; and refer to sites capable of providing simple or complex surgeries
- Provide adjunct therapies such as nutrition, physical therapy for foot drop, general hygiene, treatment for dermatitis from urinary leaking, urinary tract infections or anemia, assessment and support for emotional disturbances, e.g. depression
- Offer conservative treatment for selected clients (catheterization for women with urinary leakage post-delivery)
- Provide pre-operative care such as fistula counseling, obtaining informed consent for procedure/surgery, laboratory studies and bowel preparation.
- Routine nursing care would be available twenty-four hours, seven days a week for all in-patient services.

<sup>&</sup>lt;sup>1</sup> The components at this level will be partially informed by the documentation of the pre-repair model that is currently being implemented in Ethiopia. Documentation is planned for the first quarter of FY08.

## Level 2: Repair of simple fistula cases

Facilities at this level would have staff and surgical teams capable of:

- Providing all of the level 1 activities
- Repairing simple fistula cases, with a surgical team skilled in pre, intra- and postoperative functions to support surgery
- Providing long-term post-operative care, in general approximately of three weeks, including the provision of meals
- Routinely and consistently scheduling simple fistula repairs in the theater and/or during regularly scheduled campaigns.
- Diagnosing, classifying and referring or deferring fistula cases that cannot be repaired at that site

### Level 3: Repair of complex fistula cases

Facilities at this would be able to:

- Carry out all the level 1 and 2 functions
- Repair simple and complex fistula cases
- Offer practical experiences in support of training for surgeons and nurses (client volume, trainer on site, etc.)
- Offer individuals who could serve as preceptors or coaches on-site to expand support for surgeons and nurses training.

# **Promoting Facilities-Based Prevention Interventions**

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At the global level, FC will focus attention on four key interventions to prevent fistula:

- Integrating family planning within fistula services
- Promoting the use of the partograph to monitor labor and delivery
- Promoting the use of the catheter to prevent or treat fistula associated with prolonged or obstructed labor
- Strengthening c-section service provision

*Integrating Family Planning into Fistula activities:* FC will continue to emphasize the importance of family planning, both as a preventive measure, as well as a measure to assist women who have had repairs to use family planning to achieve a successful pregnancy in the future or, if they have completed their families, to consider methods for limiting family size. FC will continue to collaborate with the Nigeria and two other country programs where strengthening family planning services in areas where fistula services are provided is determined to be a priority. We will assist service sites to determine the level of integration they can support, based on a framework for integration developed under the ACQUIRE project.<sup>2</sup> FC will provide short-term TA to assist in the implementation of the framework, approach and interventions in two countries to increase awareness, and increase access to counseling and services, document the process and lessons learned and share this with other programs.

*Promoting the use of the partograph to monitor labor and delivery:* The incidence of prolonged labor can be substantially reduced by use of the partograph, and therefore reduce obstructed labor and its potential sequelae, including fistula. Although the partograph has been around for more than 30 years, challenges have been experienced in the consistent use of the partograph to monitor active labor. These have included a lack of conviction on the part of providers and program managers of its utility or added value, a concern that it increases workload, whether or not an effective referral system is in place, and some features inherent to the partograph itself, like the fact that there are many versions which can be confusing, and sometimes sites simply run out of paper for the flowcharts. FC will work with countries interested in demonstrating and increasing or improving the use of the partograph – Bangladesh, Mali, Uganda, Guinea have expressed interest – to provide training and other support for its use. Where possible, we will partner with ACCESS, AMDD or other maternal health programs to assess and address challenges, amend guidelines, ensure that the nationally "sanctioned" version of the partograph is available

<sup>&</sup>lt;sup>2</sup> A national stakeholders meeting was held in Kaduna, Nigeria in July 2008 to discuss the value of integrating family planning into fistula services, a priority for the USAID Mission in Nigeria and the Nigeria fistula program. A report will be forthcoming.

and used (updated where necessary), conduct training, ensure supervisory support for its use, as well as routine reviews of progress made in reducing prolonged labors at the site. This experience will be documented and shared with other countries and sites providing labor and delivery services.

*Promoting the use of the catheter to prevent or treat fistula associated with prolonged or obstructed labor:* Immediate catheterization can be used both as a prophylaxis and for treatment. According to studies conducted by Kees Waaldijk, approximately 10% of cases may be appropriate for this kind of treatment. In the case of prophylactic use, it may require a period of 7-14 days in-hospital stay. For treatment, it may require 3-4 weeks in-hospital stay. The duration and type of hospital stay may be affected by whether open or closed drainage is used. Hospital stays may inhibit effective use of catheterization as a preventive measure. In addition, training is required to effectively recognize the type of fistula that would respond to this kind of treatment. (This training could be combined with the partograph training.) FC will work with interested countries to demonstrate and, where appropriate, increase the use of immediate catheterization after prolonged or obstructed labor – Bangladesh, Uganda, Guinea, Mali have expressed interest. Where possible, we will partner with ACCESS, AMDD or other maternal health programs. This experience will be documented and shared with other countries and sites.

Strengthening c-section service provision: Approximately 10-15% of fistula cases are iatrogenic, although it is not known what percentage of that number are related to c-sections. The DRC and Uganda in particular have expressed interest in addressing poor c-section performance as a means of reducing the number of fistula cases. Addressing this issue will require a step-wise approach to determine what policies exist regarding who can do c-sections, what training or refresher training is required, what reference materials, equipment and supplies are in place or required, the availability of blood, training in life-saving skills, etc. As mentioned previously, FC will utilize the AMDD *Quality Improvement for Emergency Obstetric Care Leadership Manual and Toolbook* to assist sites in determining where improvements are required more generally in emergency obstetric care. FC will work in two countries (the DRC will be one) to strengthen c-section service delivery.