the fistula hospital addis ababa

In 1959, Doctors Reg and Catherine Hamlin left successful careers in obstetrics and gynaecology in Sydney, Australia, to set up a school of midwifery for nurses in the Princess Tsehai Memorial Hospital in Addis Ababa, Ethiopia on a three-year contract. They were totally unaware of the obstetric complications that they would see, which eventually became their life's work.

Geographically, Ethiopia is split by the Rift Valley. To the north, there are high mountains and deep ravines formed by the headwaters of the Blue Nile. To the south, the lowest points in Africa are massive expanses of furnace-like deserts. Many villages are only accessible by foot, and a three-day walk would not be uncommon to reach a main road to get to one of the few country hospitals, which are chronically short of equipment and trained staff.

In developed countries, vesicovaginal and rectovaginal fistulae are rare and usually occur following surgery, cancer or radiotherapy. In Ethiopia, prolonged obstructed labour in the squatting position for periods of up to seven days, far from any medical help, results in the birth of a dead baby, with total incontinence of either urine, faeces, or both. The first symptoms occur approximately 10 days later, after the ischaemic bladder and rectal walls have separated. Over 50% of these women are deserted by their husbands. Some, subjected to traditional therapy, have their legs bound together to try and cure the leak resulting in contractures of their hips and knees. A further 20% will develop unilateral or bilateral foot drop and are therefore unable to walk or carry out the traditional roles of a woman, fetching water and working in the fields. They usually have to beg or sell an animal to raise money to get to the hospital and are often brought by their father or uncle, carried on their back or on the back of a donkey. They are not allowed on public transport because of their offensive smell.

The Hamlins began operating on these young women, and as word of their success spread, they soon became inundated with patients. It was obvious that a new hospital, devoted specifically to the treatment of fistula patients, was required. The Hamlin Churchill Charity was set up and has continued to support the hospital since it opened in 1975 and was extended and refurbished in 1998 (*Fig. 1*). The hospital receives no state aid and relies totally on charitable donations.

Figure 1

Reg Hamlin died in 1993, but Catherine still continues their work with four Ethiopian gynaecologists now performing the majority of the surgery. Around 30,000 fistula patients have been treated, and approximately 1,300 operations are carried out each year. The nursing staff is a mixture of fully trained nurses, but some are patients who were incurable or had some form of urinary diversion which meant that they could not go back to their village. They have been trained in all aspects of the care of fistula patients. One patient, Mamutu, came to the hospital at the age of 16 and has been taught to operate. She is the prime teacher of trainees in obstetrics and gynaecology from the local teaching hospital who spend three months at the Fistula Hospital. Another role of the Fistula Hospital is the teaching of doctors from other parts of the world where fistulae are rife; they spend a month learning fistula surgery. Unfortunately the demand is so great that the waiting time for these doctors to visit the hospital is now three years.

All the fistula repairs are carried out transvaginally, and 91% of those with a vesicovaginal fistula are cured, although some will still have a degree of stress incontinence, or severe frequency due to a small contracted bladder.

My connection with the hospital began almost 15 years ago when I was invited by the British Council to act as an external examiner for the final MB BS exams of the University of Addis Ababa. I visited the Hamlins and subsequently have become a regular visitor, going three or four times a year, not to repair fistulae but to teach the Ethiopian gynaecologists how to reconstruct those that they cannot cure.

I remember my first operation so well. This was the first abdominal operation that had been performed at the Fistula Hospital. It was on a young woman, Lete Kedani, a fistula patient with no bladder, who had developed bilateral ureteric strictures and was dying of renal failure. The only option was to perform an ileal conduit. Lete withstood the operation with no problems then or subsequently, and it is a delight to see her every time I return there (*Fig. 2*). Very few patients have an ileal conduit because there would be no appliances for them when they return to their village, thus I initially taught them how to carry out a ureterosigmoidostomy. However with the introduction of the Mainz II pouch, this is now the standard method of diversion and is also the one we have introduced to the teaching hospital for the treatment of children with

bladder extrophy. Some women with no bladder have had an entero-cystoplasty or a new bladder constructed, the limitation being their need to live near the hospital. Often one or both ureters are stuck to the side wall of the pelvis and cannot be reimplanted transvaginally. In those with unilateral injuries it is better to perform a transureteroureterostomy rather than operate again on a very small bladder. For those with bilateral problems, reimplanting the ureters into a small piece of ileum sutured to the dome of the bladder is the operation of choice. Sometimes it is necessary to do a nephrectomy or stone surgery on the bladder or ureter.

Figure 2

Intravenous urography (IVU) has become available over the last three to four years; prior to that, you obtained a very careful history, a full physical examination and then did what was necessary after the abdomen had been opened and the ureters and bladder identified. At the end of a long day's operating, I would often find I was exhausted, not because of the altitude or the complexity of the surgery but due to breathing in the open ether used as an anaesthetic. This has been unavailable over the last three years, and now halothane is regularly used.

My teaching of the Ethiopian gynaecologists, Ambaye and Mulu, seems to have been successful, and though I still visit three to four times a year I am spending more time at the teaching hospital where I intend to make my future. Strictures, prostates, stones and hypospadias are the most frequently encountered urological problem, and I have been fortunate to attract a number of UK urologists who have been prepared to give up their time and at their own expense come and teach stricture and hypospadias surgery.

One of the major problems at the teaching hospital is the chronic lack of equipment. Once it is broken, a major problem particularly with electrical equipment because of power surges, there is nobody to repair it. However with the aid of a generous grant from the British Ambassador and Ethiopiaid, I am hoping shortly to bring a medical technician over to London to learn to maintain and repair equipment with the eventual plan of setting up a school of medical technology within the medical school.

A fully-equipped physiotherapy unit has been set up at the Fistula Hospital to treat the contractures and foot drop (*Fig. 3*) as a result of the efforts of my daughter's school, who adopted the hospital as their charity for the year. A nurse from the Hospital has been trained in Australia, and regular visits take place between physiotherapists in the UK and the Fistula Hospital to reinforce the nurses' training and to train other members of staff.

The Fistula Hospital provides total care for these young women from the moment they arrive to the time they are discharged, cured, with new clothes, money and a ticket to get home.

What is required is the prevention of the occurrence of these fistulae. The rights of women should be

Figure 3

respected; they and their families require education against the practice of childhood marriage, and such marriages should not be condoned by the religious leaders. Much needs to be done to remove rural poverty and provide adequate health care facilities so that women likely to suffer from obstructed labour are identified early and facilities for Caesarian section made freely available. The nearly to be opened extension to the Fistula Hospital which will provide homes, security and a livelihood for women whose injuries were so severe that they cannot return home, would then become unnecessary.

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