

By Karen Roush, MSN, NP

# A Fistula Clinic Repairs Lives in Uganda

*A complication of obstructed labor shatters women's lives.*

**A**gnes stood in the doorway, clutching her walking stick. Urine dripped from beneath the brightly colored cloth wrapped around her waist, puddling at her feet on the cement. She made her way down the steps by twisting her body, a compensation for bilateral footdrop. When she reached the grass she tossed aside her walking stick and took four proud steps unassisted.

Agnes is one of an estimated 2 million women and girls in developing countries who suffer from obstetric fistula, a devastating complication of obstructed labor. I met the 16-year-old in July at the Kitovu Health Care Complex in Masaka, Uganda, a rural area of subsistence farming at the edge of Lake Victoria just south of the equator. It's the site of a fistula clinic established by Sister Maura Lynch, a nun and surgeon who came to Uganda 20 years ago with the Medical Missions of Mary.

Obstetric fistula is unheard of in the developed world, where women have access to skilled obstetric care. In countries like Uganda, where according to the World Health Organization only 39% of births are attended by a skilled birth attendant, obstructed labor may go on for days. A prolonged labor compresses the tissues of the vagina, and also the bladder or rectum or both, between the baby's skull and the mother's pelvis, causing hypoxia and necrosis. The result is a hole, leaving the woman unable to control the passage of urine or feces. (Temporary paralysis and footdrop can also result from sustained pressure against the sciatic nerve during obstructed labor.)

Ostracized by husbands, families, and communities, these women and girls endure isolation and extreme hardship. "They are so ashamed," Sister Maura said. "They think it's their fault, that they did something



Photos courtesy of Karen Roush

wrong.” To hide the leakage women stuff rags between their legs and cover them with plastic bags. The soaked rags cause chafing, ammonia burns, and ulcerations. The women may avoid drinking, leading to dehydration, urinary tract infection, and kidney disease. They are grieving as well; obstructed labor that is prolonged enough to cause fistula inevitably results in the infant’s death.

Poverty is the primary cause of obstetric fistula. There is no money to pay for care or for transportation to a hospital or clinic. Traditional birth attendants, whose livelihoods depend on the income they receive for their services, assure mothers that they can care for them even if complications occur. Some midwives perform an episiotomy with a razor to facilitate delivery. After what is sometimes days of labor, the mother will finally be transported to the hospital, often on the back of a “boda-boda”—a bicycle or motorcycle taxi.

Compounding the problem is the fact that many girls in rural areas are married by the age of 12. The immaturity of their bodies, coupled with chronic malnutrition, results in a high incidence of cephalopelvic disproportion. Also, home delivery is desired, and mothers are expected to deliver vaginally; those who can’t are considered unwomanly or cursed.

In Masaka, Sister Maura has established programs that address some of these issues, including educating husbands and traditional birth attendants. After surgery, a woman stays at the hospital until fully healed, to reduce the risk of reopening the fistula by resuming sexual relations too soon (a woman doesn’t have the right to refuse sex with her husband).

Sister Maura trains Ugandan surgeons and volunteers from other countries who come to Masaka for “fistula camps.” At the last camp, 89 women underwent surgical repair, with a success rate of 88%—one that Sister Maura is happy with. “Some women are so damaged, there’s no tissue left,” she said.

The services are offered at no cost; the United Nations Population Fund (UNFPA) provides most of the funding, about \$400 for each repair. Women hear about an upcoming “camp” through radio



◆ At the Kitovu Health Care Complex in Masaka, Uganda, 16-year-old Agnes awaits surgical repair of fistula, a complication of prolonged obstructed labor.

announcements or community health workers and walk for days, if necessary, to reach the clinic. Sister Maura said they are “shattered” if they come and can’t be repaired, which happens when funds are low.

When I met Agnes she was awaiting surgery. She had been carried into the Kitovu clinic a few weeks earlier in a fetal position, believing she was still paralyzed. When Sister Maura showed her that she could move her legs Agnes responded with a joy that was still evident in her smile as she took those difficult steps across the grass.

For information on how you can help, contact Sister Maura Lynch at [kitovu@ucmb.co.ug](mailto:kitovu@ucmb.co.ug), or visit the UNFPA fistula Web site, [www.endfistula.org](http://www.endfistula.org). ▼

*Karen Roush is AJN’s editorial director. Contact author: [karen.roush@wolterskluwer.com](mailto:karen.roush@wolterskluwer.com). Correspondence from Abroad is coordinated by Gerald Martone, MS, RN ([gerald@theirc.org](mailto:gerald@theirc.org)), and Richard Garfield, DrPH, RN ([rmg3@columbia.edu](mailto:rmg3@columbia.edu)).*