Factors associated with loss to follow-up in women undergoing repair for obstetric fistula in Guinea

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Abstract

OBJECTIVES To analyse the trend of loss to follow-up over time and identify factors associated with women being lost to follow-up after discharge in three fistula repair hospitals in Guinea.

METHODS This retrospective cohort study used data extracted from medical records of fistula repairs conducted from 1 January 2007 to 30 September 2013. A woman was considered lost to follow-up if she did not return within 4 months post-discharge. Factors associated with loss to follow-up were identified using a subsample of the data covering the period 2010–2013.

RESULTS Over the study period, the proportion of loss to follow-up was 21.5% (448/2080) and varied across repair hospitals and over time with an increase from 2% in 2009 to 52% in 2013. After adjusting for other variables in a multivariate logistic regression model, women who underwent surgery at Labe hospital and at Kissidougou hospital were more likely to be lost to follow-up than women operated at Jean Paul II hospital (OR: 50.6; 95% CI: 24.9–102.8) and (OR: 11.5; 95% CI: 6.1–22.0), respectively. Women with their fistula closed at hospital discharge (OR: 3.2; 95% CI: 2.1–4.8) and women admitted for repair in years 2011–2013 showed higher loss to follow-up as compared to 2010. Finally, loss to follow-up increased by 2% for each additional kilometre of distance a client lived from the repair hospital (OR: 1.002; 95% CI: 1.001–1.003).

CONCLUSION Reimbursement of transport was the likely reason for change over time of LTFU. Reducing geographical barriers to care for women with fistula could sustain fistula care positive outcomes.

Keywords Obstetric fistula, loss to follow-up, Guinea, Conakry, Fistula care

Introduction

According to the recent estimates, the lifetime prevalence of obstetric fistula in women aged 15–49 years is 1.57 per 1000 in sub-Saharan Africa [1, 2]. In Guinea, 6 per 1000 of women of reproductive age carry the lifetime risk of experiencing obstetric fistula [3]. Although significant progress has been made in more than 50 countries in the prevention and management of obstetric fistula, significant gaps remain [4]. First, access to emergency obstetric care including skilled birth attendance in many countries in sub-Saharan Africa is still low [5]. Second, despite high fistula closure rates (80–90%) observed after surgery [6, 7], studies in sub-Saharan Africa have reported late repair breakdown ranging from 2.6% to 4.3% between 6 and 24 months after discharge from hospital [8–10]. Third, the loss to follow-up rates for women discharged after repair can be high [8, 11].

Data on the post-repair period in fistula programmes are scarce, but in the literature, the young maternal age, low maternal level of education, housewife/unemployed mothers, transportation costs related to long distances to the hospital and inadequate counselling at facilities are often reported to be associated with LTFU in maternal health programmes in developing countries [12, 13].

There is no standard prescribed time period for follow-up after fistula repair. However, a routine post-operative visit at 3–6 months is usually reported [8, 11, 14, 15].
Bishinga et al. reported 40% and 80% loss to follow-up at 3 and 6 months, respectively, among 479 women repaired for fistula at the Medecins Sans Frontieres (MSF) supported Gitega Fistula Centre in Burundi, and Browning et al. reported 40% loss to follow-up among 390 women at 6 months post-repair at the Bahar Dar Hamlin Fistula Centre in Ethiopia [8, 11]. In Burundi, the authors could not examine all the factors associated with loss to follow-up because of limited available information. In Ethiopia, the authors underlined the importance of monitoring late breakdown and emphasised the need for reinforcing follow-up after repair to sustain long-term outcomes for programmes [8, 16].

Previous reports show that repair breakdown can occur after discharge [9, 10] or, conversely, that incontinence may either improve or resolve after discharge [8]. Therefore, from a programme perspective, the 3 months follow-up visit provides useful information about the dynamic of repair outcomes over time [11], while from the woman’s perspective, it is an opportunity for the doctor to confirm the closure/continence status and release her to resume daily activities including sexual relations, as it is routine practice in many fistula repair programmes to advise women not to perform heavy work or resume sexual relations for 3 months post-op [15]. Furthermore, if the repair has broken down, the visit is an opportunity to provide continued care to the woman and can identify her current needs. Following up women after repair is essential to better understand their reintegration process, their health status including any persistent urinary symptoms and their quality of life in the post-repair period [9, 17]. Therefore, understanding the predictors of loss to follow-up is important for optimising care.

In 2007, EngenderHealth (an international reproductive health non-governmental organisation) helped to establish and strengthen fistula management services at three hospitals in Guinea through the Fistula Care project [18]. An evaluation of the repair outcomes from these facilities was published in a previous paper [19]. In this study, our objective was to analyse the trend of loss to follow-up over time and identify factors associated with women being lost to follow-up after discharge in three fistula repair hospitals in Guinea.

**Methods**

**Study design**

This was a retrospective cohort study using data extracted from medical records of all fistula repairs conducted from 1 January 2007 to 30 September 2013 at three hospitals in Guinea.

**Setting**

Guinea is among the poorest countries in the world with the majority (65%) of its 12 million inhabitants living in rural areas and a maternal mortality ratio of 724 per 100 000 live births [3]. The maternity units of three urban hospitals in three regions of Guinea (Jean Paul II Hospital in Conakry, the Regional Hospital of Labé and the Prefectural Hospital of Kissidougou) where obstetric fistula repair was supported by the Fistula Care Project. Each three hospitals were staffed by two or three surgeons, an anaesthetist, a counsellor and two to four nurses all trained in fistula prevention and management. They collectively performed on average 300–400 fistula surgical repair per year. Treatment in these hospitals was free and included assessment and surgical repair by a surgeon, and counselling about exercises, family planning methods, and restrictions on sexual intercourse and heavy labour up to 3 months post-repair [19].

**Study population and participants**

We included all women originating from Guinea (N = 2080) who underwent fistula repair in each of the three hospitals between 1 January 2007 and 30 September 2013. Women coming from outside Guinea (36 women, 1.7% of the total sample) were excluded from this study because they were originally given financial support for residence in nearby facility-sponsored social houses and could therefore bias the results.

**Data and key indicators**

The socio-demographic and clinical characteristics of fistula patients available from patient records included the following: age at admission at hospital (in years), marital status (single, married, divorced or widow), residence (rural or urban), woman’s occupation (housewife or worker –defined as working for pay), level of education (none versus primary or higher), duration of fistula (in years), place of delivery (home, home with traditional birth attendant and health structure), neonatal outcome (alive and stillborn), mode of delivery (vaginal and Caesarean section), type of obstetric fistula (vesicovaginal fistula – VVF, rectovaginal fistula – RVF, and both – VVF + RVF), previous repairs, residential distance from the repair centre and year of surgery (2007 to 2013).

Treatment outcomes were fistula closure (Yes or No) continence status after surgery at hospital discharge (Yes or No), assessed by a dye test prior to hospital discharge. Loss to follow-up (LTFU), defined as the woman failing to return for a follow-up visit within 4 months after
being discharged, was recorded as a dichotomous variable (Yes or No). Study data were abstracted from patients’ files kept at each fistula care repair hospital by two members of the study team, using structured forms. Data were extracted from medical records between 1 April and 31 August 2014 and covered 69 months, from 1 January 2007 to 30 September 2013.

Data analysis

Data collected from patients’ files were double-entered by two independent encoders into EpiData software (EpiData Association, Odense, Denmark). The two data files were compared and discordances resolved by cross-checking with the paper registers. Data were analysed using STATA 13 software (STATA Corporation, College Station, TX, USA). We used the whole sample (N = 2080) to summarise demographic and clinical characteristics, treatment outcomes and LTFU using frequencies (%) and means (with standard deviation). Because essentially in the early years, there was no variation of LTFU to examine, we considered the subsample of women operated from 2010 to 2013 at the three repair hospitals for the bivariate and multivariate analyses. Pearson’s chi-square test (\( \chi^2 \)) or Student’s \( t \)-test were used, respectively, to compare proportions or means of variables between women lost to follow-up and those not lost to follow-up with a level of significance set at \( P = 0.05 \) and a 95% confidence interval. A logistic regression model was used to derive the unadjusted and adjusted odds ratios. The significance level was set at 5% and a 95% confidence interval (95% CI). A logistic regression model was used to derive the unadjusted and adjusted odds ratios. The significance level was set at 5% and a 95% confidence interval. All study variables were considered \( a \) \( p\)riori for inclusion in the logistic regression model looking at factors associated with LTFU. Adequacy of the final model was tested by the Hosmer and Lemeshow test for goodness of fit.

Ethics approvals

Ethics approval was obtained from the Guinean National Ethics Committee for Health Research and the Scientific Committee of the Department of Public Health of the Faculty of Medicine of the University of Conakry.

Results

Sociodemographic and clinical characteristics

Overall, 2080 women originating from Guinea underwent surgical repair for female genital fistula at the three repair hospitals. Table 1 shows the demographic and clinical characteristics of these women. More than half of the repairs (1083, 52%) were done at Kissidougou hospital. The mean age at presentation was 34 ± 12 years. The majority of women (\( n = 1413, 69\)%) were married or in union, had no level of education (1865, 94%) and had vesicovaginal fistula (2011, 98%). Only 5% (101 women) had a livebirth for the referent pregnancy.

Loss to follow-up

Of the 2080 women repaired between 2007 and 2013, 448 women were reported LTFU (21.5%, 95% CI, 19.8–23.3). There was little variation in the overall proportion of LTFU in the early years of the Fistula Care Project (2007–2009), while this proportion varied drastically between repair hospitals and over time, increasing from 2% in 2009 to 52% in 2013 (Figure 1).

Bivariate analyses

In bivariate analyses, the demographic and clinical characteristics of women LTFU were similar to those who were not LTFU (1632 women) at presentation. LTFU was significantly associated with repair hospital, age of the woman at admission, duration of fistula, level of education, place of delivery, continence status at discharge and year of surgery (Table 2).

Women operated at Labe hospital (odds ratio (OR): 13.2; 95% confidence interval (95% CI): 8.8–19.7) and Kissidougou hospital (OR: 4.9; 95% CI: 3.3–7.3) were more likely to be lost to follow-up than women operated at Jean Paul II hospital. The odds of LTFU increased by 1% for each additional year of age at presentation (OR: 1.01; 95%CI: 1.00–1.01) and 2% for each additional year of duration of fistula (OR: 1.02; 95% CI: 1.00–1.03). The odds of LTFU were higher among women with no education (OR: 2.4; 95%CI: 1.3–4.4), and those giving birth at home (OR: 1.7; 95%CI: 1.1–2.6). Women not continent at discharge (OR: 1.8; 95%CI: 1.4–2.4) and those admitted for surgery from 2011 to 2013 (OR: 2.8; 95%CI: 2.0–3.9), (OR: 2.2; 95% CI: 1.5–3.1) and (OR: 6.4; 95% CI: 4.4–9.4), respectively, were more likely to be lost to follow-up than those in 2010.

Multivariable analysis

After adjusting for possible confounding factors (Table 2), LTFU status remained significantly associated with repair hospital, continence status at discharge and year of surgery. Distance between the repair hospital and a woman’s residence became significant after adjusting for other variables.
Women who underwent surgery at Labe hospital and at Kissidougou hospital were more likely to be LTFU than women operated on at Jean Paul II hospital (OR: 50.6; 95% CI: 24.9–102.8) and (OR: 11.5; 95% CI: 6.1–22.0), respectively.

The odds of LTFU was higher among women with their fistula closed at hospital discharge (OR: 3.2; 95% CI: 2.1–4.8) and women admitted in 2011 (OR: 3.2; 95% CI: 2.0–4.9), in 2012 (OR: 1.9; 95% CI: 1.2–3.1) and 2013 (OR: 5.3; 95% CI: 3.2–8.5). Finally, the odds of LTFU increased by 2% for each additional km of distance a woman lived from the repair hospital (OR: 1.002; 95% CI: 1.001–1.003).

Discussion

This study provides an overview of the factors associated with loss to follow-up after discharge of women undergoing obstetric fistula repair in Guinea. About 22% of women who underwent repair for obstetric fistula between 2007 and 2013 were LTFU.

Women who underwent surgery at Labe hospital and at Kissidougou hospital were more likely to be LTFU than women operated on at Jean Paul II hospital (OR: 50.6; 95% CI: 24.9–102.8) and (OR: 11.5; 95% CI: 6.1–22.0), respectively.

The odds of LTFU was higher among women with their fistula closed at hospital discharge (OR: 3.2; 95% CI: 2.1–4.8) and women admitted in 2011 (OR: 3.2; 95% CI: 2.0–4.9), in 2012 (OR: 1.9; 95% CI: 1.2–3.1) and 2013 (OR: 5.3; 95% CI: 3.2–8.5). Finally, the odds of LTFU increased by 2% for each additional km of distance a woman lived from the repair hospital (OR: 1.002; 95% CI: 1.001–1.003).

Table 1 Demographic and clinical characteristics of Guinean women undergoing repair for obstetric fistula in three hospitals from 2007 to 2013 in Guinea (N = 2080)

| Variables | Mean (SD) or Median (IQR) | Number (%) |
|-----------|---------------------------|------------|
| Total     | 2080                      |            |
| Repair hospital |                     |           |
| Jean Paul II hospital | 549 (26.4) | 178 (8.6) |
| Labe hospital | 448 (21.5) | 178 (8.6) |
| Kissidougou hospital | 1083 (52.1) | 178 (8.6) |
| Mean age at reception (SD), years | 34.2 (12.3) | 178 (8.6) |
| Residence |                             |            |
| Rural     | 1890 (91.2)                | 178 (8.6) |
| Urban     | 182 (8.8)                  | 178 (8.6) |
| Mean number of previous repairs (SD) | 0.63 (0.88) | 178 (8.6) |
| Mean duration of fistula (SD), years | 9.9 (9.0) | 178 (8.6) |
| Marital status |                     |            |
| Single    | 79 (3.8)                  | 178 (8.6) |
| Married/Union | 1413 (68.7) | 178 (8.6) |
| Divorced/Separated | 375 (18.2) | 178 (8.6) |
| Widow     | 189 (9.2)                  | 178 (8.6) |
| Occupation |                             |            |
| Housewife | 1991 (96.9)                | 178 (8.6) |
| Worker    | 64 (3.1)                   | 178 (8.6) |
| Level of education |                 |            |
| None      | 1865 (94.1)                | 178 (8.6) |
| Primary & higher | 118 (5.9) | 178 (8.6) |
| Mean parity (SD) | 3.5 (2.5) | 178 (8.6) |
| Place of delivery |                     |            |
| Home      | 463 (22.8)                 | 178 (8.6) |
| Home with traditional birth attendants (TBA) | 217 (10.7) | 178 (8.6) |
| Health structure | 1354 (66.5) | 178 (8.6) |
| Neonatal outcome |                     |            |
| Alive     | 101 (4.9)                  | 178 (8.6) |
| Stillborn | 1944 (95.1)                | 178 (8.6) |
| Mode of causal delivery |                 |            |
| Vaginal   | 1353 (66.3)                | 178 (8.6) |
| Caesarean section | 687 (33.7) | 178 (8.6) |
| Type of obstetric fistula |           |            |
| Vesicovaginal fistula (VVF) | 2011 (96.7) | 178 (8.6) |
| Rectovaginal fistula (RVF) | 23 (1.1) | 178 (8.6) |
| VVF + RVF | 46 (2.2)                   | 178 (8.6) |
| Fistula status after surgery |           |            |
| Closed    | 1726 (89.5)                | 178 (8.6) |
| Not closed | 203 (10.5) | 178 (8.6) |
| Continence status at discharge |           |            |
| Continent | 1653 (79.6)                | 178 (8.6) |
| Not continent | 423 (20.4) | 178 (8.6) |
| Year of surgery |                     |            |
| 2007      | 178 (8.6)                  | 178 (8.6) |
| 2008      | 181 (8.7)                  | 178 (8.6) |
| 2009      | 246 (11.9)                 | 178 (8.6) |

Table 1 (Continued)

| Variables | Mean (SD) or Median (IQR) | Number (%) |
|-----------|---------------------------|------------|
| Year of surgery |                     |            |
| 2010      | 381 (18.4)                | 178 (8.6) |
| 2011      | 493 (23.8)                | 178 (8.6) |
| 2012      | 369 (17.8)                | 178 (8.6) |
| 2013      | 227 (10.9)                | 178 (8.6) |
| Mean distance from repair hospital (SD), km | 260.7 (180.5) | 178 (8.6) |

SD, Standard deviation.
outcomes of fistula programmes, particularly those including social reintegration and long-term follow-up after repair.

We found that women who underwent surgery at Labe hospital and at Kissidougou hospital were more likely to be lost to follow-up than women operated at Jean Paul II hospital. One reason for this might be the geographical distribution of clients. Jean Paul II hospital is located in the capital city Conakry where transportation to and from surrounding localities is easy and cheap, allowing more women to come back for their follow-up visit. In contrast, Labe hospital (Middle Guinea) and Kissidougou hospital (Forest Guinea) are located in mountainous regions where the repair hospitals are far and not always easily accessible by women coming from remote areas. Another reason might be the way counselling sessions prior to discharge were conducted across repair hospitals might have differed (for instance the interaction between clients and providers). The odds of LTFU increased by 13% for each additional 50 km of distance a client lived from the repair hospital, suggesting that women living further away from repair hospitals were more likely to miss their follow-up visits. Distance to repair site has already been identified as a barrier to access to fistula care by Bishinga et al. [11] and Browning et al. [8] who reported high loss to follow-up rates [9] and sustain good outcomes at discharge in many studies [6, 19, 24, 25].

In our context, there is a need to improve the coordination mechanism between repair hospitals to ensure every woman suffering from fistula is referred to the nearest repair hospital. The mean distance between a woman’s residence and repair hospital observed in this study (261 ± 181 km) shows that many women were repaired far from their residence because repairs were planned in periodic repair sessions. Some women were sent from one repair hospital to another, depending on the availability of the surgery team.

Women who were successfully closed and dry at discharge (continent) were less likely to return for their 3 months follow-up visit. Previous studies have reported higher closure and continence rates in women with relatively simple and recently occurred fistula [24, 25]. This suggests that women with more complex fistula might give up their search for care and decide not to return for follow-up. These women are probably demoralised after years of living with their fistula and suffering of intractable social exclusion [26, 27]. However, Browning et al. [8] have reported from Ethiopia that 96.1% of those who returned for follow-up after 6 months were not completely healed at the time of discharge (including women with residual incontinence), while only 49.1% of those who were healed at discharge returned. Possible

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Figure 1 Annual trend in the proportions of loss to follow-up among women undergoing surgical repair for obstetric fistula in three repair hospitals in Guinea, 2007 to 2013.

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Table 2 Logistic regression identifying factors associated with being lost to follow-up among women who have undergone fistula repair in three repair hospitals from 2010 to 2013 in Guinea (N = 1475)

| Variables                               | Women LTFU | Bivariate analysis | Multivariate analysis |
|-----------------------------------------|------------|--------------------|-----------------------|
|                                         | N (%)      | Unadjusted OR (95% CI) | Adjusted* OR (95% CI) |
| Total                                   | 1475       | 1                  | 1.50 (0.98–2.34)      |
| Repair hospital                          |            |                    |                       |
| Jean Paul II hospital                    | 33 (7.7)   | 1                  | 1.00 (0.98–1.02)      |
| Labé hospital                           | 13.17 (8.79–19.73) | 50.6 (24.86–102.98) |
| Kissidougou hospital                    | 4.89 (3.30–7.26) | 11.55 (6.07–22.00)  |
| Age at reception, years                 | 36.1 (12.4) | 1.01 (1.00–1.02)   | 1.00 (0.98–1.01)      |
| Residence                               |            |                    |                       |
| Rural                                   | 398 (29.0) | 1                  | 1.00 (0.98–1.02)      |
| Urban                                   | 32 (22.3)  | 1.17 (0.75–1.81)   | 1.02 (0.54–1.95)      |
| Number of previous repairs              | 0.65 (0.9) | 1.05 (0.93–1.20)   | 1.05 (0.88–1.25)      |
| Duration of fistula, years              | 10.8 (8.9) | 1.02 (1.00–1.03)   | 1.00 (0.97–1.02)      |
| Marital status                          |            |                    |                       |
| Single                                  | 11 (22.0)  | 1                  | 1.00 (0.98–1.02)      |
| Maried/Union                            | 292 (28.2) | 1.39 (0.70–2.76)   | 0.75 (0.32–1.73)      |
| Divorced/Separated                      | 67 (29.8)  | 1.50 (0.73–3.11)   | 0.77 (0.32–1.87)      |
| Widow                                   | 53 (35.8)  | 1.98 (0.94–4.18)   | 0.89 (0.34–2.34)      |
| Occupation                              |            |                    |                       |
| Housewife                               | 415 (29.4) | 1.82 (0.84–3.96)   | 0.62 (0.24–1.62)      |
| Worker                                  | 8 (18.6)   | 1                  | 1.00 (0.97–1.02)      |
| Level of education                      |            |                    |                       |
| None                                    | 400 (30.6) | 2.41 (1.32–4.41)   | 0.64 (0.36–1.14)      |
| Primary & higher                        | 13 (15.5)  | 1.50 (0.73–3.11)   | 0.77 (0.32–1.87)      |
| Parity                                  | 3.8 (2.5)  | 1.01 (0.97–1.06)   | 0.98 (0.95–1.02)      |
| Place of delivery                       |            |                    |                       |
| Home                                    | 117 (32.7) | 1.68 (1.09–2.60)   | 1.36 (0.77–2.40)      |
| Home with TBA                           | 35 (22.4)  | 1                  | 1.00 (0.97–1.02)      |
| Health structure                        | 268 (29.1) | 1.42 (0.95–2.12)   | 1.16 (0.67–2.01)      |
| Neonatal outcome                        |            |                    |                       |
| Alive                                   | 30 (36.6)  | 1.44 (0.90–2.29)   | 1.30 (0.71–2.37)      |
| Stillborn                               | 390 (28.6) | 1                  | 1.00 (0.97–1.02)      |
| Mode of causal delivery                 |            |                    |                       |
| Vaginal                                 | 276 (28.8) | 1                  | 1.00 (0.97–1.02)      |
| Caesarean section                       | 143 (29.7) | 1.05 (0.82–1.33)   | 1.06 (0.73–1.55)      |
| Type of obstetric fistula               |            |                    |                       |
| Vesicovaginal fistula (VVF)             | 415 (29.2) | 1.97 (0.55–6.74)   | 1.66 (0.40–6.82)      |
| Rectovaginal fistula (RVF)              | 3 (17.7)   | 1                  | 1.00 (0.97–1.02)      |
| VVF + RVF                               | 12 (31.6)  | 2.15 (0.52–8.93)   | 1.36 (0.26–7.07)      |
| Continence status at discharge          |            |                    |                       |
| Continent                               | 322 (26.7) | 1                  | 1.00 (0.97–1.02)      |
| Not continent                           | 106 (39.7) | 1.81 (1.37–2.38)   | 3.20 (2.15–4.79)      |
| Year of surgery                         |            |                    |                       |
| 2010                                    | 55 (14.4)  | 1                  | 1.00 (0.97–1.02)      |
| 2011                                    | 158 (32.1) | 2.80 (1.98–3.94)   | 3.17 (2.04–4.92)      |
| 2012                                    | 99 (26.8)  | 2.17 (1.51–3.14)   | 1.95 (1.23–3.11)      |
| 2013                                    | 118 (52.0) | 6.42 (4.36–9.44)   | 5.26 (3.24–8.52)      |
| Distance from repair hospital (km)      | 249.6 (178.6) | 0.98 (0.942–1.010) | 1.002 (1.001–1.003)   |

OR, Odds ratios; CI, Confidence interval; LTFU, Loss to follow-up.
Hosmer–Lemeshow test for goodness-of-fit: \( \chi^2 \) (8 d.f.) = 9.80; \( P = 0.28 \).
*Multivariate analysis adjusting for possible confounding factors. Bold figures show significant confidence intervals.
explanations they provided were that (i) women who were cured at discharge were more likely to reintegrate into a normal social life, resume sexual intercourse and become pregnant again in the short term; and/or (ii) they do not feel it is important to attend the follow-up because they consider themselves cured [8, 16].

The main limitation of this study was that it was based on data from medical records only, and no additional qualitative data were collected on why women did not return for follow-up. For women who did not return, we were unable to establish their closure and continence status at 3 months post-op nor were we able to evaluate their mental health status. Poorer mental health has been reported to be present in women with poorer acute outcomes [8]. Finally, we were unable to characterise the sample in relation to all women who have experienced fistula, or to the average woman in Guinea (for instance using Demographic and Health Survey data). However, this is one of the few studies to examine factors associated with loss to follow-up in women undergoing repair for obstetric fistula in low income countries using such a large dataset.

Conclusion

This study shows that repair hospital, fistula status at discharge, year of surgery and distance from repair hospital were the main factors associated with loss to follow-up status post-discharge in women repaired for obstetric fistula in Guinea. Providing resources to reduce geographical and financial barriers (in particular transportation costs) for women suffering from fistula, improving pre-discharge counselling and implementing active follow-up strategies could reduce LTFU and improve fistula programme performance. More mixed methods research, both qualitative and quantitative, is needed to trace women who are lost to follow-up to understand patients’ reasons and motivations for not returning for follow-up visits and the cultural and family dynamics that influence these decisions.

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