A TRAINING CURRICULUM

Counseling

the Obstetric Fistula Client

USAID
FROM THE AMERICAN PEOPLE

FistulaCare

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Contents

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Acronyms and Abbreviations

AIDS	acquired immune deficiency symdrome
AMDD	Averting Maternal Death and Disability [Program]
COPE®	client-oriented, provider-efficient
DMPA	depot medroxyprogesterone acetate
HIV	human immunodeficiency virus
HSIP	home site implementation plan
IUD	intrauterine device
LAM	lactational amenorrhea method
MAP®	Men As Partners®
NCI	National Cancer Institute [U.S.]
NET-EN	norethisterone enanthate
OC	oral contraceptive
QI	quality improvement
REDI	Rapport Building, Exploration, Decision Making, and Implementing the Decision
RVF	rectovaginal fistula
SEER	Surveillance, Epidemiology and End Results [Program]
SIECUS	Sex Information and Education Council of the United States
STI	sexually transmitted infection
TBA	traditional birth attendant
UNFPA	United Nations Population Fund
USAID	U.S. Agency for International Development
VVF	vesicovaginal fistula
WHO	World Health Organization
WST	whole-site training

Introduction for the Trainers

Course Overview

Course Goal and Objectives

Counseling is an integral part of comprehensive obstetric fistula care services and is one set of functions conducted by nurses, midwives, and physicians providing care. ***Counseling is defined*** as a two-way communication process of helping clients make informed and voluntary decisions about their individual care. Counseling mainly involves a one-to-one interaction between the client and the provider, although it may also include the client's partner or another support person whom the client has requested to be present.

There are three components of fistula care—Prevention, Treatment, and Reintegration; each of these components has a unique set of core counseling competencies involving individual and couple counseling and group education (with family members, community members, and other women living with fistula):

CORE COMPETENCIES FOR COUNSELING RELATED TO PREVENTION

The following elements should be incorporated into existing pregnancy-related counseling:

Preconception Counseling

- Explain the causes of fistula
- Explain how to prevent fistula through girl-child nutrition and immunization, delay of early childbearing, nutrition, and use of family planning
- Engage partners and/or others influencing decision making in the family

Antenatal Counseling

- Provide information on understanding danger signs during pregnancy and when to go to the hospital, accessing timely hospital services during labor, and making a birth preparedness plan (including making transportation plans and setting aside funds for transport)
- Engage partners and/or others influencing decision making in the family about the risk of long labor and delaying health care and about the importance of delivery being performed by a trained provider

Postnatal Counseling

- Provide information on the healthy timing and spacing of pregnancies and the family planning options available
- Provide information on optimal nutrition for woman and infant—particularly the nutritional needs of the girl infant/child

CORE COMPETENCIES FOR COUNSELING RELATED TO TREATMENT

Preoperative Counseling

- Assess client's ability to give and receive information, and explore client's needs and feelings
- Provide information on the initial assessment, possible treatment options, potential outcomes, and possible side effects, complications, and risks
- Link client with a social support group and/or resources within the facility
- Maintain emotional support through verbal/nonverbal communication, using techniques to minimize fear and anxiety
- Provide information on client's expected postoperative role in self care, catheter care, mobility, nutrition, pain management, complications/danger signs, physiotherapy, period of sexual abstinence, future childbearing, family planning needs, and need for close antenatal care and cesarean delivery with subsequent pregnancy(ies)

Intraoperative Counseling

- Protect client's privacy, and ensure respect and dignity
- Provide reassurance and comfort before administration of anesthesia
- Provide information about the anesthesia to be used, its risks, and the management of pain

Postoperative Counseling

- Maintain emotional support and monitor pain management needs during the immediate recovery period
- Provide information as indicated related to outcome of surgery, self care, catheter care, mobility, nutrition, pain management, complications/danger signs, physiotherapy, period of sexual abstinence, future childbearing, family planning needs, need for close antenatal care, and need for cesarean delivery with subsequent pregnancy(ies)
- Engage partners and/or others influencing decision making in the family about client's recovery needs, about the need for rest, follow-up at the facility, sexual abstinence, and use of family planning for delay of desired pregnancy until healing is complete, and about support for the client to receive close antenatal care and cesarean delivery with subsequent pregnancy(ies)

Discharge Counseling

- Assess client's feelings, questions, concerns regarding the recovery phase and the future
- Provide discharge information according to postoperative management plan, and information on sexual abstinence, delaying pregnancy, and management of stress incontinence
- Provide follow-up date(s)
- Assess additional psychosocial needs, link client with additional counseling services or referral for additional services, and link client with community organizations that support women with fistula repair

CORE COMPETENCIES FOR COUNSELING RELATED TO REINTEGRATION

Counseling on Physical Therapy/Physiotherapy

- Explore client's feelings about her physiotherapy progress and progress to independence

Counseling on Community/Family Reentry

- Explore client's feelings about her acceptance and functioning within the family and/or community
- Link client with community and/or social services that address her changing needs

Counseling on Livelihood

- Link client with skills-building for income-generation opportunities and management of her resources

Note: In cases where surgery was not successful, based on the client's condition, counseling related to reintegration should also provide information on: why the surgery failed; possible future procedures and options; complications and/or infections; personal hygiene and nutrition; management of incontinence; and the need to delay pregnancy until after a future procedure.

Based on these core competencies, the **goal** of this curriculum is to prepare service providers at all levels to provide information and counseling to fistula clients, including referral for treatment and recovery services and counseling for related issues outside their usual scope of work.

General Objectives

As a result of this training, providers will be able to use communication and counseling skills to perform the following counseling tasks:

- Assess the client's needs and concerns
- Provide accurate information on the following: what a fistula is, the causes of fistula, means of preventing fistula, and treatment and self care for fistula; pre- and post-operative fistula care.
- Provide support to the client and her partner/family, as appropriate before, during, and after fistula repair.
- Help the client make decisions about family planning, prevention of HIV and other sexually transmitted infections, and receipt of other reproductive health services
- Provide counseling to the client's partner and/or family (when available and with the client's permission)

NOTE TO THE TRAINERS

This volume focuses on counseling clients with *obstetric fistula*, which is generally caused by obstructed labor. However, fistula may also be caused by other factors, including sexual violence (which causes *traumatic gynecologic fistula*) or injury during assisted childbirth (which causes iatrogenic fistula). Although the clinical outcomes of different types of fistula are often similar, the counseling needs of women may be very different.

Participants in a 2005 experts' meeting on traumatic fistula identified as a key challenge in the provision of traumatic fistula care a lack of providers trained in counseling survivors of sexual and gender-based violence and the absence of standards for counseling traumatic fistula clients, as well as difficulty in maintaining continuity of care in providing the long-term psychological and emotional counseling after fistula repair.

To meet this perceived need, EngenderHealth has developed a supplement to this curriculum—*Counseling the Traumatic Fistula Client: A Supplement to the Obstetric Fistula Counseling Curriculum*. That document provides important factual material and training exercises specific to traumatic fistula, including alternative or additional Participant Handouts.

Throughout this trainer's manual, you will see pink boxes like the one shown below.

Refer to pages 19 and 20 of the traumatic fistula supplement for alternative Handout 1-B, which replaces the one in this curriculum.

If traumatic fistula is a problem in the area where the training participants will be working, or if the participants need to be trained in counseling survivors of sexual and gender-based violence, refer to the indicated pages of the supplement *Counseling the Traumatic Fistula Client*. That document provides important factual material and training exercises specific to Traumatic Fistula, including alternative or additional Participant Handouts.

If traumatic fistula is *not* a problem where the training participants will be working, just ignore the pink boxes.

Additionally, the term "obstetric fistula" is only used in this curriculum when specifically referring to that condition; the general term "fistula" is used the rest of the time.

Course Participants

This new training approach is designed specifically for providers who interact with fistula clients immediately before, during, and after treatment, including nurses, midwives, physicians, social workers, and nursing assistants. The workshop is intended to teach essential counseling skills to all providers who care for women with fistula and build on basic counseling knowledge and skills. It is assumed that participants will have clinical experience or knowledge about the treatment procedures in use at the service

site, or that this curriculum will be used along with clinical training in obstetric fistula for clinical skills and infection prevention. The training is intended for groups of six to 15 participants and is to be provided over a period of six and one-half to seven days. Many participants will need more time for small-group presentations and role plays. The training can include multiple cadres of providers, but **depending on local circumstances and levels of experience and knowledge, physicians might be asked to attend only selected portions of the training.** Regardless of the size of the group, however, participants will benefit most if the clinical practicum site has enough fistula clients to allow each participant to counsel at least two clients during the clinical practicum.

Trainers for This Course

This curriculum was designed for training conducted by skilled, experienced trainers. Although the curriculum contains information to guide the training process and to assist the trainers in making decisions that will enhance the learning experience, it is assumed that the trainers understand adult learning concepts, can employ a variety of training methods and techniques, and know how to adapt materials to meet the participants' needs.

The trainers also must be aware of standards and guidelines regarding certification, training follow-up, and ongoing supervision of the site or institution sponsoring the training event. The trainers should keep these issues in mind when reviewing the curriculum in preparation for conducting the course.

The trainers must have a solid grounding in counseling, previous experience in assisting fistula clients, and a familiarity with the treatment of complications related to treatment of fistula. A team of two trainers (either two cotrainers or a lead trainer and an assistant) is needed for this intensive training. As one trainer facilitates a session, the other can record information on flipcharts, monitor time, help keep the discussion on track with the session objectives, moderate small-group work, and act in sample role plays.

The Training Curriculum

Note on Language

Throughout this curriculum, women with fistula are referred to as *fistula clients*. In many health settings, persons receiving care are referred to as *patients*, a word that often connotes passivity and ill health. This curriculum uses the word *clients* to reinforce the concept of empowerment and to suggest an active role for the person seeking services. (See EngenderHealth. 2003. *COPE Handbook: A Process for Improving Quality in Health Services*. New York.)

Throughout this curriculum, *prevention*, *treatment*, and *reintegration* are referred to as the three core approaches to addressing fistula. In some literature, the term *rehabilitation* is used instead of *reintegration*. We use *reintegration* to refer to a more holistic approach to helping women after fistula repair, including assisting with their physical rehabilitation, providing counseling and emotional support, and supporting their social reintegration, which may include efforts to reduce stigma and discrimination and to support vocational and educational training and support.

Training Curriculum Components

The training curriculum has three main components: training sessions, participant handouts, and appendixes.

Training sessions

The methodology and instructions for conducting the training are included within the Training Sessions. The nine sessions are grouped thematically to cover related topics. Each session contains introductory information about:

- The objectives of the session and points to remember
- Suggested training methods to use and materials needed
- Advance preparation (including any special training supplies that will be needed)
- An estimate of the amount of time needed for the training

Before beginning each session, the trainers should review the session's objectives. These can be prepared in advance on a flipchart or as a handout. The objectives should be reviewed again at the end of each session, as a summary of what was covered.

In each session, a Materials section lists all of the educational and training materials needed for the session. Materials that need to be adapted, developed, or gathered in advance are noted under Advance Preparation. The estimated time that will be needed for the session's training is noted as well.

The Training Steps section gives detailed instructions for conducting the session, with a suggested time for each activity. Training Tips provide the trainer with additional background information on content or training approaches. These notes may also include discussion questions, possible responses for brainstorming exercises, and suggested formats for flipcharts. Training Tips appear in highlighted boxes following the appropriate step or at the end of the session guide.

Participant handouts

Handouts are provided to assist the trainers in conducting training activities. When reviewing the training steps for each session, trainers should read the handouts carefully and identify the key points to be covered during the group discussions. This advance preparation will facilitate the process of reviewing and summarizing handouts. The handouts for each session appear after the session activities.

Whenever possible, each participant should receive a participants' guide. If this is not possible, the trainers must make copies of the handouts they will use in each session. Alternatively, if the trainers cannot or do not wish to make copies of the handouts, they may write the content of selected handouts on flipcharts or a chalkboard. This approach will work better with some of the handouts than with others. For example, the participants will need copies of handouts that instruct them to give written responses. In addition, they might find it helpful to keep copies of handouts that contain material that is not provided elsewhere so they can review the material after the training is over.

Appendixes

The appendixes contain materials and tools to be used in conjunction with training activities. Trainers can use these resources in their advance preparation. The appendixes are as follows:

- *Appendix A: Training Outline.* This outline shows the chronology and timing of all sessions and subsections, along with a list of the accompanying handouts. The training agenda also specifies the suggested audience for each session.
- *Appendix B: Pretest/Posttest on Obstetric Fistula Counseling.* Trainers have the option of using this test at the beginning and at the end of the training event. The trainers can use the results of the pretest to customize the training to the participants' level of counseling knowledge and experience. After the training, trainers can use the posttest to measure change in the participants' knowledge and perspectives. Answers to this test (including sample correct responses for the open-ended questions) appear immediately after the blank version of the test. The test is included as an appendix rather than as a handout because it is not a required component of the curriculum. Trainers and sponsoring institutions are free to decide on a case-by-case basis whether use of the pretest and posttest is appropriate and constructive for each particular training event.
- *Appendix C: Fistula Counseling Competency-Based Observation Checklist.* Trainers should use this checklist after observing participants during the clinical practicum. The evaluation tool will enable trainers to assess participants' counseling skills and to identify gaps that require further attention.
- *Appendix D: Transparencies and Activity Materials.* Trainers might find it useful to use transparencies or flipcharts to present content or conduct training activities. Appendix D contains sample text and images that can be reproduced and used for transparencies and flipcharts during training sessions.
- *Appendix E: Sample Case Studies.* A background explanation on the use of case studies within this training appears later in this introduction (see "The Case-Study Approach"). EngenderHealth strongly recommends that participants in this training prepare original case studies during the training event, as described in Option 1 of Session 4, Part A. In certain training situations, however, time may be too limited to complete the case-study development exercise. In such cases, trainers should refer to Option 2 of Session 4, Part A, and select three or four of the prepared case studies in Appendix E. The case studies selected should reflect a wide range of client characteristics and situations, including age, parity, marital status, and whether the client had a treatable or nontreatable fistula. These preselected case studies will then be used throughout the training and integrated into various exercises and role plays, in the same manner as would those developed by training participants.
- *Appendix F: Glossary.* The glossary defines terms related to fistula and counseling.
- *Appendix G: Additional Resources for Trainers.* There are many valuable reference materials on care for clients with fistula. Trainers should obtain and review as many of the materials as possible before to the training.
- *Appendix H: Sample Client-Education Material.* Following the training, participants or institutions might request client-education materials that reinforce critical instructions on postprocedure/community care and that provide information on family planning options for women with fistula.
- *Appendix I: Cross-Cutting Issues.* EngenderHealth trainings include sessions on cross-cutting issues such as whole site training, quality improvement, infection prevention, Men As Partners®, and stigma and discrimination related to HIV and AIDS. While this curriculum does not address these issues in full, information on these topics has been included and can be adapted to relate to fistula.

- *Appendix J: Workshop Evaluation Form.* Just as the pretest/posttest on fistula counseling (Appendix B) is an important aspect of evaluating the impact of the training, the Workshop Evaluation Form is a vital aid in helping EngenderHealth to improve the curriculum. Thus, all participants should be asked to complete the evaluation form at the end of the training, and all completed forms should be sent to EngenderHealth.
- *Appendix K: Sample Client Records and Consent Form.* This appendix contains helpful examples of the sorts of records forms that the trainer can share with training participants to help them understand how service data can be captured and appreciate the need to obtain informed consent. The trainers should feel free to introduce participants to these sample forms at a relevant point in the training.
- *Appendix L: Sample Fistula Counseling Checklist and Counseling Register.* This appendix contains examples of a tool for assessing the quality of counseling and/or as a job aid for the person conducting counseling, to make sure that the required information has been shared with the client.

Training Materials, Supplies, and Equipment

Along with the materials provided as part of the curriculum, the trainers should obtain training aids, such as flipchart paper, masking tape or blue tack, and colored markers, for use during the course. In addition, some training activities might require the use of index cards or large or small pieces of paper.

This training relies heavily on the use of flipcharts to guide or summarize discussions. Most of these can be prepared in advance. However, there are dangers in overusing flipcharts:

- Paper is expensive and sometimes scarce.
- Participants can become bored with "training by flipchart," even though it is meant to make the training interactive.
- Participants need to save some of the information, and handouts might work better in such cases.

Specific instructions are given for when to write on the flipchart and when not to in each session; try not to do more than is suggested.

If an overhead projector, transparencies, transparency markers, and electricity are available, then transparencies can be used in addition to or instead of flipcharts (see participant handouts and Appendix D for material that can be presented using transparencies or flipcharts). Handouts can also be read during the session and then kept for participants' later reference. Here are a few guidelines for when to use flipcharts, transparencies, and handouts:

- Use flipcharts if you are recording suggestions or ideas from participants (e.g., during brainstorming), if you want to post the information on the wall or refer to it later in the training, or if you want the participants to think through a question or concept by themselves (maybe referring to a handout later).
- Use an overhead projector and transparencies if you want to present a piece of text for everyone to read and discuss but not save or if you want to post instructions for group work.
- Use handouts if you want the participants to save the information to refer back to after the training.

Session 6, "Counseling for the Obstetric Fistula Client," includes the option of using a video camera to record role-plays and then giving the participants the chance to see themselves on tape. Trainers are free to decide whether the use of video is appropriate and constructive within this session. If trainers choose to

use video, they will need to obtain a video camera and tape, plus a monitor to play the tape for the group. Trainers should familiarize themselves with the use of this equipment before the training to avoid delays resulting from technical difficulties. The main purpose of the exercise should not be sacrificed because of distractions related to the video equipment.

How to Use These Materials

Training Design

This curriculum has been designed to be flexible, to accommodate different cadres of participants (doctors, nurses, social workers, etc.), different levels of participant experience, and different social and cultural settings. The course design will be determined in part by the participants' prior experience and training. While service providers' time might be limited during onsite training, it is preferable that all participants be present for all sessions (see Appendix A).

The exercises in this curriculum have been carefully designed to achieve specific objectives. Although trainers will need to adapt certain portions of the training based on the setting, culture, and other local factors, they should follow the instructions as closely as possible.

Use of Training Methods

The curriculum relies on a combination of training methods, including presentations and interactive exercises, and instructions are provided within the steps of the training sessions. Although the trainers will need to present some of the material through lectures, they will also use participatory methods, such as large-group and small-group exercises, role plays, and discussion. The trainers should never lecture for more than 15–20 minutes at a time. While lecturing, they should use visual aids to illustrate the narrative.

Participatory methods such as brainstorming and role-play exercises have been shown to be a critical feature of successful adult learning. Although the methods used for this training should be as interactive as possible, both to reduce the amount of lecture time and to engage the participants more fully, the content of the course does not always lend itself to such activities. The trainers can also employ principles of adult learning by encouraging the participants to discuss issues and generate solutions based on their own experiences.

Time Frame

The suggested duration for this training is six and one-half to seven days, including both in-class training and hands-on counseling practice with fistula clients. However, the training might last 7–10 days, depending on the participants' level of knowledge and skills in counseling and reproductive health and on the flow of the practicum session. If the trainers make changes to the length of the training, they might also need to change the order of sessions in order to adapt the course to time constraints.

The Case-Study Approach

This curriculum is intended to be adaptable across different cultures. To address the range of sensitive issues related to fistula in different countries, participants' input is used to create client profiles that reflect the unique situation in their setting. These client profiles are developed into case studies that are used repeatedly throughout the training for small-group work and role plays. The case studies allow the participants to

develop empathy toward clients by applying new dynamics to individual clients' personal situations. Creating client profiles and case studies that accurately cover the range of local issues and challenge providers' stereotypes, biases, and misconceptions requires close attention and sensitivity on the part of the trainers. Throughout the curriculum, guidance is given to help the trainers to consider the possible range of issues that need to be addressed and to lead discussions into potentially difficult areas.

The Clinical Practicum

Note: Practicum site preparation should be carried out well in advance of training and consistent with EngenderHealth training standards.

The clinical practicum (see Session 10) is a crucial element of the curriculum. After completing the interactive classroom portion of the training, participants are given hands-on practice in applying their skills to counseling sessions with actual clients. Working in pairs, participants take turns providing counseling to fistula clients before, during, and after treatment procedures, under the observation of a supervisor and one other participant. (If there is a shortage of clients, trainers may arrange for two participants to observe a counseling session.) The clinical setting provides a context in which to apply the lessons covered in class, and it elevates the skill practice to a level of seriousness difficult to approximate in classroom role plays. The clinical practicum is critical to the impact of the overall training experience, and each participant should counsel a minimum of two clients so that he or she can practice adapting the discussion content to individuals' actual circumstances. The exposure to multiple clients will help participants see how dramatically counseling needs vary from one client to the next.

Note: The classroom/didactic portion of the training must be planned carefully to ensure that essential services can still be provided at sites where participants are working and that there is good client mix and an adequate number of fistula clients at the facility during the training period. Trainers might need to be flexible with the training schedule: They might need to start the didactics days before the surgery week or to provide some aspects of counseling earlier than currently scheduled on the agenda. While such changes are not ideal, they might be necessary to avoid disruption of services and to ensure adequate numbers of counseling experiences for participants.

Evaluation

Evaluation is an important component of training. It gives the trainers and participants an indication of what the participants have learned and helps the trainer determine whether the training strategies were effective.

The true measure of successful counseling training is whether quality counseling practices, services, and protocols have been instituted (or improved), which can only be determined through follow-up of training events. However, more immediate evaluation of the course itself is also needed. Because this course covers both knowledge-based and attitude-based material, participants' progress will be measured in large part through the assessment of changes in their knowledge and attitudes.

Evaluation opportunities within the curriculum include the following:

- Assessing participants' progress during the training by asking questions of individuals and groups, to test their knowledge and comprehension
- Using the pretest and posttest to assess improvement or change in participants' cumulative knowledge and attitudes
- Observing role plays and the clinical practicum to assess how participants' counseling skills have developed from the middle to the end of the training

During the clinical practicum, trainers and/or supervisors should use the Fistula Counseling Competency-Based Observation Checklist (see Appendix C) to observe the participants as they counsel fistula clients. The goal of this assessment is to identify strengths and weaknesses in the participants' counseling skills. Using the scored checklists, trainers should discuss with the participants, on an individual basis, ways in which to improve their counseling skills. The participants' results should be kept by trainers and used as a baseline. The results can also be used to identify participants who have exemplary counseling skills and who might be candidates to become counseling trainers in the future. The curriculum suggests a score that would be considered passing, although this score may be adapted for local conditions.

After the training event, the trainers or another qualified professional should follow up with the participants to learn how they have applied their new knowledge and skills. If a supervisor is responsible for follow-up, the trainers should contact the supervisor to learn how the counseling of fistula clients has improved in the participant's setting as a result of his or her training.

An end-of-training course evaluation allows the participants to provide feedback on the overall training process and results. The Workshop Evaluation Form (Appendix J) should be used for this purpose, and the participants should be encouraged to be truthful in their responses. (This might be easier for them if they complete the handout anonymously.)

Finally, this is a new training approach for the counseling of fistula clients; evaluation is very important if EngenderHealth is to further improve the curriculum. Please use the evaluation form provided to obtain feedback from each participant, and please return all completed forms to EngenderHealth.

Advance Preparation

Selection of Training Participants

Careful selection of participants is integral to the success of the training program. If possible, the training participants should have had some experience in providing services for fistula clients, should be committed to working with fistula clients, should be committed to training co-workers on-the-job until they are competent, and should intend to work in a fistula-related service for a minimum of two years. Where possible, participants should be selected from sites where facility administrators and supervisors are committed to providing fistula care services.

Obtaining Background Information

Before the training begins, the trainers should try to find out as much as they can about the course participants—their job responsibilities, background, sex, and experience with providing care to women with obstetric fistula—and about the management hierarchy at their work sites, so the training can be adapted to the participants' needs. In addition, the trainers should try to determine what plans are in place at the participants' sites regarding comprehensive fistula services in general and counseling for fistula in particular. For example, if the site currently provides little or no counseling for fistula clients, or if protocols related to this subject do not exist, the trainers should find out:

- Why the site requested the training
- What the training will entail beyond counseling (e.g., infection prevention, quality improvement, Men As Partners® in reproductive health, clinical skills, and family planning) and work with site staff to organize orientation and update sessions either during the training or during follow-up
- Who is responsible for supervision of services, including counseling, for women with fistula
- What role the participants currently or will soon play in the provision of counseling services for fistula clients

To obtain this information, EngenderHealth recommends that trainers interview the administrators who are most involved with training at the participants' respective sites. To assess the participants' needs and abilities before training, the trainers can interview them and observe them during service provision or administer the optional pretest on fistula counseling (Appendix B).

Guidelines for Training Preparation

The following steps should assist the trainers in becoming familiar with the curriculum and preparing to conduct the training event. (*Note:* Each participant should receive a copy of the Participant Handbook. If for some reason it is impossible to provide handbooks to each participant, the trainer must plan on making copies of handouts instead.)

1. First, read the entire curriculum and the handouts one time quickly to get an overall sense of the purpose, content, and approach of the training.

2. Next, confer with the program administrators at the service site. If you have been asked to present this training, they are probably well aware of its goals, objectives, and intended audience. Nevertheless, after you have first read the curriculum, you should meet with them to clarify the purpose of the training, to see if appropriate participants have been selected, and to confirm the time committed for the workshop.

3. Then read the curriculum again, this time slowly. Think about each session in terms of the needs of fistula clients and service providers at the local service sites. Carefully review each handout—the handouts are the permanent record of the workshop that participants will take with them, and others who did not attend the training might also see them. Revise them as necessary to reflect and be sensitive to the local situation, issues, and attitudes.

4. After you have reviewed and revised (if necessary) the handouts, make enough copies of them for all of the participants. (*Note:* Some handouts can be given out at the beginning of the training for the participants to read as background. Other handouts are meant to be distributed as part of a training

activity.) Each participant should have a notebook or folder for keeping all of his or her materials organized as they are distributed; trainers should ask the facility manager to notify all of the participants in advance of the need for them to bring a notebook or folder.

5. Write the list of objectives for all sessions on a flipchart. At the beginning of each session, briefly state the objectives to be covered. Review the session's objectives during a "wrap-up" to provide a framework for assessing how well objectives were achieved and where there might be gaps in the participants' understanding. (These gaps can be addressed in subsequent sessions.)

Additional Resources for Trainers

Before the training, the trainers should obtain and review as many of the materials listed in Appendix G as possible. (The materials can be obtained either from EngenderHealth or from the publisher.) The curriculum sometimes refers to specific materials as starting points for group discussions. Depending on the participants' level of training and interest, trainers might wish to select one or two of these references to copy and distribute as handouts. Beware, however, that giving the participants all of the materials might overwhelm them and might not be the best use of materials and financial resources.

During the Training Course

Creating a Positive Learning Environment

Many factors contribute to the success of a training course. One key factor is the learning environment. Trainers can create a positive learning environment by:

- *Respecting each participant.* Trainers should recognize the knowledge and skills that the participants bring to the course. They can show respect by learning and using the participants' names, encouraging them to contribute to discussions, and requesting their feedback on the course agenda.
- *Giving frequent constructive feedback.* Constructive feedback—particularly during role plays and clinical practice—increases people's motivation and ability to learn. Whenever possible, trainers should recognize the participants' correct responses and actions by acknowledging them publicly and making such comments as "Excellent answer!" "Great question!" and "Good work!" The trainers can also validate the participants' responses by making such comments as "I can understand why you would feel that way." The trainer should also help participants recognize incorrect practices and develop a plan for improving performance.
- *Keeping the participants involved.* The trainers should use a variety of training methods that increase participant involvement, such as questioning, case studies, discussions, and small-group work.
- *Making sure that the participants are comfortable.* The training room(s) should be well lit, well ventilated, and quiet, and should be kept at a comfortable temperature. Breaks for rest and refreshment should be scheduled.

Participant Feedback

The trainers should set aside a segment of time at the beginning of each training day to permit the participants to raise issues that can interfere with learning, such as those related to personal situations, accommodations, or content. Depending on the size of the group, a period of 10–15 minutes might be needed.

Similarly, the trainers should set aside a segment of time at the end of each training day to allow the participants to share their learning insights and their assessment of what did and did not go well for them that day. This assessment will enable the trainers to make any needed adjustments in the agenda and give the participants the opportunity to comment on the way the training course is progressing. One effective way for the trainers to do this is to conduct a "plus/delta" exercise, which is described below.

At the end of the day before the last training day (e.g., on day six of a seven-day training), the trainers might ask the participants if they would like anything discussed in the training to be clarified or if they would like anything else to be included on the last day.

Conducting a Plus/Delta Exercise

Plus/delta exercises can be used to solicit feedback about the training workshop. Through these exercises, training participants are able to evaluate the workshop experience together, discussing aspects of the workshop that went well and recommending ways to improve it in the future. This exercise can be conducted at the end of each day or at the end of the whole workshop.

Conducting a plus/delta exercise can take between 15 and 30 minutes. The trainer asks the participants to call out aspects of the workshop that they liked. The trainer then records them in the left-hand column of a flipchart entitled "Plus" (or "What I Liked about This Workshop"). Next the trainer asks the participants to call out one way to improve the workshop and records it in the right-hand column of a flipchart entitled "Delta" (or "What Could Be Done to Improve This Workshop").

For each item listed in the "Delta" column, the trainer facilitates a discussion by asking whether many people agree or if only one participant feels this way and by encouraging the participants to recommend ways to make the suggested changes. The trainer continues asking for ways to improve the workshop until the participants have no more suggestions. (*Note:* If the participants seem reluctant to point out negative aspects of the training, the trainer might mention one way that he or she has thought of to improve future trainings.)

If the participants' suggestions for improvement involve changes to the training room or environment, the trainer should communicate the suggestions to someone who can facilitate the changes.

Adjusting the Curriculum

As the course progresses and the trainers become familiar with the participants' learning styles and level of knowledge, they might need to make minor adjustments in the course content or agenda. Time requirements for the training sessions will vary, depending on the participants' experience and interests and on the trainers' respective levels of experience.

Adjustments to the curriculum should be few and should not compromise the quality of the training. The trainers should cover all important content—in the order prescribed by the agenda and training sessions—and allow sufficient time for discussion.

At the End of the Training Course

It is important to summarize the content and activities of the course. The trainer should highlight key points and be sure to review any specific concerns or difficulties that were raised during the course.

When the training has concluded, the trainers may choose to administer the posttest (Appendix B) to assess changes in the participants' knowledge and attitudes regarding fistula counseling. It is also important for the participants to complete the end-of-training evaluation (Appendix J), so the trainers can examine overall processes and results.

After the Training Course

Follow-Up

Learning about counseling women with fistula does not end when this course is completed. At the end of the training, most of the participants will have gained new knowledge and skills and will have a better understanding of how to integrate comprehensive, quality counseling into their routine interactions with fistula clients. At the end of the course, the trainers might work with the participants to develop an action plan that outlines ways to implement new knowledge and skills gained during the course. When reviewing the action plans with the participants, the trainers should discuss the need for and possibility of carrying out whole-site training (WST) on fistula issues at the trainees' site(s). (See Appendix I for an overview of the WST methodology.)

After the course, the trainers should follow up with supervisors and/or administrators at the participants' sites to determine whether the new counseling skills are being utilized in the provision of all services for women with fistula. When making follow-up visits (e.g., through WST), trainers should discuss fistula issues with appropriate facility authorities and, when possible, should observe the provision of care to fistula clients.

Some participants might encounter difficulties in integrating counseling into their work sites if they do not have the cooperation of their colleagues and the support of their supervisors. For these and other reasons, the trainers should discuss follow-up with supervisors before the training and with the participants during the training. Where possible, supervisors and facility administrators should be oriented to fistula care and should explore the implications for changes in existing services in order to provide fistula care services. This orientation will help supervisors to be more effective in supporting providers to practice their newly acquired skills.

Before beginning the training, the trainers should understand their role in follow-up. Follow-up can be provided in several different ways, depending on the participants' needs, the trainers' availability, and financial considerations. Follow-up mechanisms include the following:

- *Visiting the participants at their sites.* This is the most effective way to follow up on the course, particularly if the participants have developed an action plan with goals and objectives. If possible, trainers should find an opportunity to facilitate a discussion with the participants to talk about the challenges and successes of integrating comprehensive counseling into existing services. Administrative issues and any problems the participants might encounter can be discussed at this time.

- *Inviting the participants to visit other sites or meet other providers who provide quality comprehensive counseling for women with fistula.* Making visits to other sites enables the participants to observe and obtain helpful advice from providers who have successfully integrated comprehensive counseling into services for women with fistula.
- *Working with site administrators and supervisors to develop a logbook for fistula clients at sites where providers have recently been trained.* Logbooks can be used to track detailed counseling information for each client, including whether the client has received counseling, her reproductive intentions, the family planning method she has selected, and referrals for other services (if applicable). This information can be reviewed to assess progress in providing client-centered counseling. However, staff, trainers, and administrators must take care not to misinterpret the data or to overload the health management information system; the emphasis should be on having the staff at the local site use the data to improve their own services. Counseling and services should match the needs of the individual clients.

Follow-up is a crucial part of training and is an integral part of any training course. The participants should know who will conduct follow-up, how it will be conducted, and when and how often it will occur.

Session 1
Opening Session

Session Objectives

During this session, the participants will:

- Share their expectations of the workshop
- Explain the workshop goals and objectives
- Establish workshop norms and logistics
- Name the three elements that form the core of a comprehensive approach to addressing fistula

Refer to page 8 of the traumatic fistula supplement for an alternative list of Points to Remember.

POINTS TO REMEMBER

✓ Counseling is an integral part of the comprehensive approach to obstetric fistula care services.

✓ The three elements that make up the core approach to addressing obstetric fistula are:

Prevention

- Early methods of prevention, such as nutrition, education for girls, avoidance of early childbearing, and family planning
- Immediate prevention, with essential and emergency obstetric care

Treatment

- Referral to appropriate health facilities (within the community and to/from other health facilities)
- Access to surgical treatment, including preoperative and postoperative care
- Counseling and emotional support

Reintegration

- Social reintegration, including reduction of associated stigma/discrimination and the development of vocational training and support
- Physical rehabilitation
- Counseling and emotional support

Training Methods

- Presentation
- Small-group work
- Large-group discussion

Materials

- Flipchart paper, easel, markers, and tape
- Paper and pens (for taking notes)
- Copies of the pretest (if appropriate)

Refer to pages 9 through 11 of the traumatic fistula supplement for alternative Appendix B—Pretest/Posttest on Fistula Counseling, which replaces the one in this curriculum, or develop your own, using items from each version of the pretest/posttest.

- Participant Handout 1-A: Workshop Goals and Objectives
- Participant Handout 1-B: Workshop Schedule

Refer to pages 12 through 13 of the traumatic fistula supplement for alternative Handout 1-B, which replaces the one in this curriculum, or develop your own workshop schedule to reflect the incorporation of traumatic fistula materials into the training.

- Copies of *Family Planning: A Global Handbook for Providers* (World Health Organization and Johns Hopkins Bloomberg School of Public Health Center for Communications Programs)

Advance Preparation

1. Send invitations to guests and arrange for speakers.
2. Provide speakers with the workshop goals, objectives, and schedule, so they have a context for their remarks.
3. Prepare a flipchart listing the objectives of this session.
4. Prepare a flipchart listing the three questions about the participants' expectations for the workshop (see page 19).
5. Prepare flipcharts showing the definition of counseling (see page 19) and the three elements of comprehensive fistula management (see page 20).

Refer to page 14 of the traumatic fistula supplement for alternative flipcharts that replace those on page 20.

6. Review all of the handouts and make one copy for each participant, guest, and speaker.
7. Arrange the room for a formal presentation, and arrange for refreshments, if appropriate.
8. Obtain enough copies of the *Family Planning: A Global Handbook for Providers* to distribute to the participants at the end of the session, along with assigned reading for Session 7.

Expectations for the Workshop

- What do you expect to learn from this workshop?
- Why is counseling an important aspect of providing care for women with fistula?
- When, during service delivery, should counseling be included for women with fistula?

Definition of Counseling

- ***Counseling*** is a two-way communication process of helping clients make informed and voluntary decisions about their individual care.
- Counseling mainly involves a one-to-one interaction between the client and the provider.
- Counseling may also include the client's partner or another support person whom the client has requested to be present.

Three Elements of Comprehensive Fistula Management

Prevention

- Early methods of prevention
  - Nutrition
  - Education for girls
  - Avoidance of early childbearing
  - Family planning
- Immediate prevention
  - Essential and emergency obstetric care
  - Prevention of the "three delays"
    - Delay in deciding to seek care
    - Delay in reaching a health care facility
    - Delay in receiving attention at a facility

Treatment

- Referral to appropriate health facilities (within the community and from other health facilities)
- Access to surgical treatment, including pre- and postoperative care
- Counseling and emotional support

Reintegration

- Social reintegration, including reduction of stigma/ discrimination and development of vocational training and support
- Physical rehabilitation
- Counseling and emotional support

Session 1 Training Steps

Session Time (total): 2 hours, 10 minutes, to 2 hours, 20 minutes

PART A: REGISTRATION AND PRETEST

Time: 55 minutes

Activity: Registration and Pretest *(55 minutes)*

1. Welcome and introduce the participants. (*5 minutes*)
2. Register all of the participants. (*5 minutes*)
3. Conduct the pretest (where applicable). (*45 minutes*)

Refer to pages 12–13 and 15–18 of the traumatic fistula supplement for alternative Appendix B—Pretest/Posttest on Fistula Counseling and Appendix C—Pretest/Posttest on Fistula Counseling Answer Key, which replace those Appendixes in this curriculum.

PART B: OPENING CEREMONY

Time: 30 minutes

Activity: Presentation *(30 minutes)*

1. Welcome and introduce the participants, guests, and speaker(s).
2. Invite the speaker(s) to offer opening remarks.
3. Lead an icebreaker exercise. For example, it might be helpful to ask each participant to briefly describe how counseling for women with fistula relates to his or her work.
4. Conduct the opening ceremony in a manner that is appropriate to local customs and observant of all necessary protocols. Include refreshments, if appropriate.
5. Begin the content-related portion of the session by asking the participants for their definition of "counseling"; reveal the prepared flipchart with the definition of counseling and acknowledge or correct the participants' responses.
6. Introduce the participants to the topic of fistula, reveal the prepared flipchart on comprehensive fistula management, and discuss the three elements.

TRAINING TIP

If there are speakers during this session, meet with them before the workshop to provide them with a context for their remarks. The speakers should emphasize the importance of the workshop and remind the participants of the official support of the ministry of health (or other key stakeholders) for the program.

Since only 30 minutes are allotted for the opening ceremony, limit the number of speakers to only a few and remind them that time is short. Additional guests and speakers can be invited for the closing ceremony.

Optional 10-minute break as guests depart

PART C: WORKSHOP INTRODUCTION

Time: 1 hour, 10 minutes

Activity 1: Presentation *(30 minutes)*

1. Distribute Participant Handout 1-A and briefly review the goals and objectives of the workshop.
2. Distribute Participant Handout 1-B and briefly review the daily schedule, including breaks and lunch.

Refer to pages 12 through 13 of the traumatic fistula supplement for alternative Handout 1-B, which replaces the one in this curriculum, or distribute your own workshop schedule.

3. Negotiate the schedule and ground rules with the participants.
4. Discuss other logistical issues, such as lodging, per diem, and transport.

Activity 2: Small-Group Work and Large-Group Discussion *(40 minutes)*

1. Divide the participants into small groups of three or four each.
2. Display the prepared flipchart entitled "Expectations for the Workshop."
3. Ask each group to briefly discuss and answer each question. One participant in each group should take notes and list responses on a piece of flipchart paper. *(15 minutes)*
4. Ask the note takers to report back to the full group on the groups' discussion of the first question. Repeat this procedure for the second and third questions. *(15 minutes total for responses)*

TRAINING TIP

All of the groups must answer and share responses to *all three* of the questions on the flipchart.

5. Summarize the participants' responses and address differences between the participants' expectations and what the workshop will actually cover.

6. Explain that any participant whose expectations still do not match the goals and objectives of the workshop should see one of the trainers before the end of the day, or as soon as is feasible, to clarify the participant's purpose in attending the training and to determine whether the workshop is appropriate for him or her. *(10 minutes)*

Refer to page 19 of the traumatic fistula supplement for a Supplemental Resource describing training steps for an additional activity.

Session 1 Handouts

Participant Handout 1-A

Workshop Goal and Objectives

Goal

This training will prepare all levels of service providers to meet the information and counseling needs of fistula clients, including referral for fistula treatment and recovery services, and counseling on related issues.

General Objectives

This training will ensure that providers have the knowledge, attitudes, and skills needed to carry out the following key communication and counseling tasks:

- Assess the client's needs and concerns
- Provide accurate information on the following: what a fistula is, the causes of fistula, means of preventing fistula, and treatment and self care for fistula; pre- and post-operative fistula care.
- Provide support to the client and her partner/family, as appropriate, before, during, and after fistula repair.
- Help the client make decisions about family planning, prevention of HIV and other sexually transmitted infections, and receipt of other reproductive health services
- Provide counseling to the client's partner and/or family (when available and with the client's permission)

Participant Handout 1-B

Workshop Schedule

Session	Participants	Time
Session 1: Opening Session		Morning, Day 1
Part A: Registration and Pretest	All	
Part B: Opening Ceremony	All	
Part C: Workshop Introduction	All	
Session 2: Providers' Values and Attitudes	All	
Session 3: Understanding Obstetric Fistula		Afternoon, Day 1
Part A: Description of the Problem	Nonphysicians	
Part B: Causes of Obstetric Fistula	Nonphysicians	
Part C: Health and Social Consequences of Obstetric Fistula	Nonphysicians	
Part D: Reasons Why Women Do Not Seek Care	Nonphysicians	
Part E: Prevention of Obstetric Fistula	Nonphysicians	
Session 4: Understanding the Client's Perspective		
Part A: Developing Case Studies of Obstetric Fistula Clients	Nonphysicians	
Part B: Confidentiality, Privacy, and Dignity	All	Morning, Day 2
Part C: Addressing the Client's Feelings	All	
Part D: Sexuality Issues	All	
Session 5: Interpersonal Communication		Afternoon, Day 2
Part A: Two-Way Communication	All	
Part B: Verbal and Nonverbal Communication	All	
Part C: Active/Effective Listening	All	
Part D: Asking Open-Ended Questions	All	
Part E: Using Simple Language and Visual Aids	All	
Part F: Counseling Framework: REDI	All	

Session	Participants	Time
Session 6: Counseling for the Obstetric Fistula Client		Morning, Day 3
Part A: Overview of Counseling	All	
Part B: Counseling for Obstetric Fistula Clients	All	Morning and Afternoon, Day 3
Part C: Counseling Women with Special Needs	All	Morning, Day 4
Session 7: Family Planning Information and Health Related Counseling		
Part A: Rationale	All	
Part B: Informed Choice	All	
Part C: Individual Client Circumstances	Nonphysicians	
Session 8: Counseling for the Client's Family		Afternoon, Day 4
Part A: Overview of Counseling for the Client's Family	All	
Part B: Counseling during Admission and the Preoperative Period	Nonphysicians	
Part C: Counseling after Surgery	Nonphysicians	Morning, Day 5
Part D: Counseling at Discharge	Nonphysicians	
Session 9: Supporting the Obstetric Fistula Client		Afternoon, Day 5
Part A: Forming Client Support Groups within a Facility	Nonphysicians	
Part B: Using Success Stories	Nonphysicians	
Part C: Contacting Community Support Networks	Nonphysicians	
Session 10: Clinical Practicum	All	Day 6 and Morning, Day 7
Session 11: Workshop Wrap-Up	All	Afternoon, Day 7

Session 2
Providers' Values and Attitudes

Refer to pages 22 through 25 of the traumatic fistula supplement for an alternative Session 2 Overview—Session Objectives, Points to Remember, Training Methods, Materials, Advance Preparation, and Training Tip.

Session Objectives

During this session, the participants will:

- Define the following terms: informed choice, informed consent, values, and attitudes
- Discuss the importance of being respectful and nonjudgmental toward all clients, regardless of their values, social status, or personal situation
- Explain the importance of being aware of one's own values and attitudes and avoid imposing them on clients
- Explain the differences between the terms "sex," "gender," "gender equity," and "gender equality"
- Discuss the differences between rules of behavior for men and rules of behavior for women, and how these gender rules affect the lives of women and men
- Explore the participants' own attitudes about gender differences, roles, and inequalities
- List common rumors and myths about fistula explaining how these may hamper clients' ability to prevent fistula and to access treatment
- Explore ways to correct misconceptions, rumors, and myths that clients or their families and communities might have about fistula

POINTS TO REMEMBER

- ✓ Informed choice is a voluntary, well-considered decision that an individual makes on the basis of options, information, and understanding.
- ✓ Informed consent is the communication between a client and a provider that confirms that the client has made an informed and voluntary choice to use or receive a medical method or procedure.

(continued)

POINTS TO REMEMBER *(continued)*

- ✓ Every interaction between a client and the health care staff—from the time she enters the health care system until she is discharged—affects the client's satisfaction with her care, how quickly she recovers, and how well she takes care of herself after she leaves the facility.
- ✓ Our values, attitudes, feelings, gender differences, gender inequalities and biases affect how we treat a client's condition.
- ✓ Myths and misperceptions play a role in lack of fistula prevention, unwarranted stigma and discrimination, and poor access to treatment.
- ✓ Targeted counseling plays a key role in dispelling any myths or misperceptions that clients and their families have about why fistula occurs and how it can be treated and prevented.

Training Methods

- Warm-up
- Large-group exercise
- Discussion
- Skit

Materials

- Flipchart paper, easel, markers, pens, pencils, five small pieces of paper for each participant, and tape
- Participant Handout 2-A: Counseling, Informed Choice, Informed Consent, and the Rights of the Client
- Participant Handout 2-B: Informed Consent in Fistula Care
- Participant Handout 2-C: Informed Consent Protocol
- Participant Handout 2-D: Informed Consent Form
- Participant Handout 2-E: Ambiguous Figure
- Participant Handout 2-F: The Gender Game
- Participant Handout 2-G: Gender
- Participant Handout 2-H: Values and Attitudes in the Provision of Health Care Services
- Participant Handout 2-I: Sample Myths and Misperceptions about Fistula
- Trainer's Resource 2-A: Informed Consent Discussion Questions/Exercise
- Trainer's Resource 2-B: Answers to the Gender Game
- Trainer's Resource 2-C: Examples of Flipcharts for "Act Like a Man" and "Act Like a Woman"
- Trainer's Resource 2-D: Sample Values Statements

Advance Preparation

1. Prepare a piece of flipchart paper listing the objectives of this session.
2. Make a copy of Trainer's Resource 2-A, cut the discussion questions into strips, fold them, and place them in a bowl.
3. Review the list of values statements (Trainer's Resource 2-D). Select seven statements to use in this exercise, adding other statements if necessary. The statements are listed in random order, so you will need to decide which one you want to read first, second, and so on (see Training Tip in Activity 5).

TRAINING TIP

The values statements in Trainer's Resource 2-D should not be distributed as a handout, because the participants (or others who read the materials) might misunderstand the intent of this exercise and think that these statements reflect the beliefs of EngenderHealth and/or the trainers. The trainers may add values statements that reflect local beliefs and values

4. Make five separate signs: STRONGLY AGREE, AGREE, STRONGLY DISAGREE, DISAGREE, and UNSURE. Post these signs on three walls, in spaces where people can gather near them.
5. Arrange the tables and chairs so that participants can move easily between the signs.
6. Review all of the participant handouts for this session.
7. Write "Myths about Fistula" on a piece of flipchart paper and post it on the wall. (Add additional sheets during the group brainstorming session, if necessary.)

Session 2 Training Steps

Session Time (total): 3 hours

PART A: INFORMED CHOICE, INFORMED CONSENT, AND THE RIGHTS OF THE CLIENT

Time: 1 hour, 15 minutes

Activity 1: Discussion *(1 hour, 15 minutes)*

1. Ask the participants to share their understanding of the differences between "informed choice" and "informed consent."
2. Distribute Participant Handout 2-A, review the definitions, and draw the participants' attention to the definitions and differences presented in the document. *Emphasize* that adhering to clients' rights requires service providers to ensure a client's access to full and accurate information, particularly before a procedure or surgery.

Refer to pages 26 through 32 of the traumatic fistula supplement, Supplement 2A, which cover an additional topic—The Mental Health–Physical Health Connection and Providers' Role in Psychosocial Care—that should be addressed at this point.

3. Distribute Participant Handout 2-B and give the participants 15 minutes to read the document.
4. Bring out the bowl containing the folded papers, go around the room, and invite volunteers to select a folded paper.
5. Give the participants 5 minutes to find the answer to their question, using the Participant Handout they have just finished reading.
6. Going in numerical order, ask the participants to read their question and provide their answer.
7. Elaborate on the participants' answers, as necessary, to ensure that they understand the informed consent process.
8. Distribute Participant Handout 2-C to participants as a resource for individual reinforcement of the informed consent process.
9. *Option:* If the training group is small or if the training is using individualized learning, this learning activity can be conducted as an individual fill-in exercise, using Trainer's Resource 2-A. After the participants complete their handout, the results can be reviewed jointly by the trainer and the participants.
10. Distribute Participant Handout 2-D and review it with the participants, going over each step.

11. Allow for the participants' questions, and clarify as needed.
12. Emphasize that the informed consent process is key to ensuring quality services consistent with clients' rights.

PART B: VALUES AND ATTITUDES

Time: 1 hour, 45 minutes

Activity 1: Warm-Up *(10 minutes)*

1. Distribute Participant Handout 2-E to each participant. Ask the participants to look at the picture and decide what it is and then to turn to the person next to them and discuss it.
2. Ask for volunteers to say what they saw. If someone describes an elderly woman, ask others to raise their hands if that is what they saw at first. If someone describes a young woman with a fancy hairstyle, ask others to raise their hands if that is what they saw first.
3. Discuss this exercise by asking the following questions:
   - Did you and your partner immediately agree on what you saw?
   - How can you explain the fact that people in the group saw two very different images in the same picture?
   - How can you apply this to your work in counseling women with fistulas?

Activity 2: Exploring Gender *(45 minutes)*

1. Explain that this session will help clarify some of the terminology that will be used in the workshop. It will also help them understand what these terms mean in their own lives.
2. Ask the participants if they can explain the difference between "**sex**" and "**gender**." After getting feedback from the group, read aloud the definitions of sex and gender in the Training Tip below.

TRAINING TIP

- **Sex** refers to the physiological attributes that identify a person as male or female.
- **Gender** refers to widely shared ideas and expectations concerning women and men. These include ideas about typically feminine/female and masculine/male characteristics and abilities and commonly shared expectations about how women and men should behave in various situations.

3. Distribute Participant Handout 2F and ask the participants to indicate if the statements refer to "sex" or "gender." After five minutes of giving the participants a chance to read and answer the statements on their own, discuss each of the answers with the entire group (referring to Trainer's Resource 2-B for the correct answers). Then distribute Participant Handout 2-G.

4. Explain that several terms related to the word "gender" also need to be explained. Ask the group if they have ever heard the term "**gender equality**." Ask them what they think it means. Allow plenty of time for discussion.

5. After getting their feedback, provide the following definition:
   - **Gender equality** means that men and women enjoy the same status. They share the same opportunities for realizing their human rights and their potential to contribute to and benefit from all spheres of society (economic, political, social, and cultural).

6. Ask the participants if the definition makes sense. Allow them to ask questions about it.

7. Invite the participants to discuss whether gender equality actually exists in their country. As the group discusses this, write on a sheet of flipchart paper any statements that explain why women do not share equal status with men in all spheres of society. Be sure to include some of the following points if they are not mentioned by the group:
   - Women in many countries are more likely than men to experience sexual and domestic violence.
   - Men are paid more than women for the same work (in most cases).
   - Men are more commonly in positions of power within the business sector.
   - Women bear the brunt of the AIDS epidemic, both in terms of total infections and in care and support for those living with HIV.

8. Ask the group if they have ever heard the term "**gender equity**." Ask them what they think it means and how it differs from gender equality. Allow plenty of time for discussion. After getting their feedback provide the following definition:
   - **Gender equity** is the process of being fair to men and women. Gender equity leads to gender equality. For example, an affirmative action policy that promotes increased support to female-owned businesses may be gender-equitable because it leads to ensuring equal rights among men and women.

9. After clarifying the definitions of gender equality and gender equity, ask the group the following questions:
   - Why should men work toward achieving gender equality?
   - What benefits does gender equality bring to men's lives?
   - How does gender inequity contribute to fistula?
   - How can gender equity contribute to preventing fistula?

10. Ask the participants to identify gender-equitable actions that men can take to help create gender equality.

Closing

A major goal of the Men As Partners® (MAP) program is to encourage communities to be more gender-sensitive, so that men and women can live healthier and happier lives, and to prevent rape, fistula, and infection with sexually transmitted infections, including HIV infection. To achieve this, we must encourage gender-equitable behaviors, such as men and women making joint decisions about their health (including when to have sex, when to use family planning methods, when to carry a pregnancy to term, when to attend antenatal care, and where to deliver), men respecting a woman's right to say no to sex, men and women settling differences without violence, and men and women sharing responsibility for parenting and for care for others.

Activity 3: Act Like a Man *(45 minutes)*

1. Ask the male participants if they have ever been told to "act like a man." Ask them to share some experiences of someone saying this or something similar to them. Ask:
   - Why do you think they said this?
   - How did it make you feel?
2. Now ask the female participants if they have ever been told to "act like a woman." Ask them to share some experiences of someone saying this or something similar to them. Ask:
   - Why do you think they said this?
   - How did it make you feel?
3. Tell the participants that you want to look more closely at these two phrases. Explain that by looking at them, we can begin to see how society creates very different rules for how men and women are supposed to behave. Explain that these rules are sometimes called "**gender norms**" because they **culturally** define what is "**normal**" for men and women to think, feel, and act. Explain that these rules restrict the lives of both women and men by keeping men in their "act like a man" box and women in their "act like a woman" box.
4. In large letters, print on one sheet of flipchart paper the phrase "Act Like a Man." Ask the participants what men are told in their community about how they should behave. Write their answers on the sheet. Compare their answers to the examples in Trainer's Resource 2-C to see the kinds of messages that are often listed and introduce these into the discussion if they have not been mentioned.
5. When the group has no more to add to the list, ask the following discussion questions:
   - Which of these messages can be potentially harmful? Why? (Place a star next to each message and discuss these one by one.)
   - How does living in the box impact a man's health and the health of others, especially in relation to fistula?
   - How does living in the box limit men's lives and the lives of those around them?
   - What happens to men who try not to follow the gender rules (e.g. "living outside the box")? What do people say about them? How are they treated?
   - How can "living outside the box" help men to positively address fistula?

6. Print on another sheet of flipchart paper the phrase "Act Like a Woman." Ask the participants what women are told in their community about how they should behave. **Write these messages on the flipchart sheet**. Check the examples on Trainer's Resource 2-C to see the kinds of messages that are often listed. Feed these into the discussion if they have not been mentioned.

7. When the group has no more suggestions to add to the list, ask the discussion questions listed below:
   - Which of these messages can be potentially harmful? Why? (Place a star next to each message and discuss these one by one.)
   - How does living in the box impact a woman's health and the health of others, including in relation to fistula?
   - How does living in the box limit women's lives and the lives of those around them?
   - What happens to women who try not to follow the gender rules? What do people say about them? How are they treated?
   - How can "living outside the box" help women to positively address fistula?

8. Next, on another piece of flipchart paper, draw a table that has a column for men and a column for women. Label this table "Transformed Men/Women." Ask the participants to list the characteristics of men who are "living outside the box." Record their answers. Once you get seven or so responses, ask the same about women who are "living outside the box." Help the participants to recognize that, in the end, characteristics of gender-equitable men and women are actually similar.

9. Ask the participants the following questions:
   - Are your perceptions about the roles of men and women affected by what your family and friends think? How?
   - Do the media have an effect on gender norms? If so, in what way(s)? How do the media portray women? How do the media portray men?
   - How can you, in your own lives, challenge some of the nonequitable ways in which men are expected to act? How can you challenge some of the nonequitable ways in which women are expected to act?

TRAINING TIP

This activity is a good way to understand perceptions of gender norms. Remember that these perceptions may also be affected by class, race, ethnicity, and other differences. It is also important to remember that gender norms are changing in many countries. If there is time, discuss with the group what makes it easier in some places for gender norms to change.

Closing

Throughout their lives, men and women receive messages from family, media, and society about how they should act as men and how they should relate to women and to other men. As we have seen, many of these differences are constructed by society and are not part of our nature or our biological make-up. Many of these expectations are completely fine and help us enjoy our identities as either a man or a woman. However,

we all have the ability to identify unhealthy messages, as well as the right to keep such messages from limiting our full potential as human beings. As we become more aware of how some gender stereotypes can negatively impact our lives and communities, we can think constructively about how to challenge them and promote more positive gender roles and relations in our lives and communities. Therefore, we are all free to create our own gender boxes and how we choose to live our lives as men and women.

TRAINING TIP

Gender refers to a set of qualities and behaviors expected from a female or male by society. Sex characteristics are what make us male or female and are based on anatomy, physiology, and genetics.

Gender roles are learned and can be affected by factors such as education or economics. They vary widely within and among cultures. Although an individual's sex generally does not change, gender roles are socially determined and can evolve over time.

Gender roles and expectations are often identified as factors hindering the rights and status of women, with adverse consequences that can affect family life, education, socioeconomic status, and health. For this reason, awareness of gender, like awareness of sexuality, is an important element of reproductive health services.

Activity 4: Discussion *(10 minutes)*

1. Ask the participants what the word *values* means and how values might affect their work when providing services to women with fistulas.
2. Summarize aloud the main points of Participant Handout 2-H concerning gender differences, gender roles, and inequalities, discuss them, and then distribute the handout to the participants.

Activity 5: Large-Group Exercise *(25 minutes)*

1. Explain that the participants will now do an exercise that will help them think about their own attitudes, about gender differences, roles, and inequalities, and about values related to clients with fistulas. Attach the five prepared signs to the walls of the training room.

TRAINING TIP

Definitions
Belief: A *belief* is something that an individual feels to be true or accurate.
Attitude: An *attitude* is the way that we think about and act toward particular people or ideas.
Value: A value is a belief that is important to an individual. Values can be influenced by religion, education, culture, and personal experiences.

2. Read aloud the following instructions:
    - I will read several statements aloud. After I read each statement, go stand under the sign that best reflects your opinion—whether you strongly agree, agree, strongly disagree, disagree, or are unsure. I will then ask one or two participants from each group to describe their thinking about this statement.
3. Read and discuss as many of the values statements as time allows (see Training Tip below).

TRAINING TIP

For this exercise to be effective, the participants must decide whether they agree with, disagree with, or are unsure about the values statements presented by the trainers. They should not submit anonymous responses to post on the signs because this will detract from the purpose of the exercise. Practice in discussing their own values will help raise the participants' awareness of how their values can affect their interactions with clients (and others).

Women living with fistula are often neglected by society and health services. In some countries, women with fistula are passed over or not provided with any services because health care providers feel powerless to do anything or do not understand the etiology and treatment options for the condition. In their communities, such women are often seen as outcasts and do not seek services, either because they fear that members of the community might feel they deserve their "punishment" or because they do not understand the treatment options. It is important for the trainers to read these statements carefully. Trainer's Resource 2-D lists the statements in random order; the trainers need to decide which statement to read first, second, and so on.

Refer to pages 33 and 34 of the traumatic fistula supplement for an alternative version of Trainer's Resource 2-D with sample values statements for you to read.

Values and attitudes related to obstetric fistula differ across settings, depending on the accessibility of quality health care, traditional practices regarding women who experience prolonged labor, the prevalence of early marriage and childbirth, and so on. Use the list in Trainer's Resource 2-D as a *guide*, and choose only the statements that are relevant for the region in which the training is conducted. The trainers should also feel free to make additions to the value statements if there are others that fit the context where the participants are working.

Before and during this exercise, it is important to emphasize that there are no right or wrong answers and that the participants may change their position on any statement after listening to the discussion. The participants will respond based on their own values and beliefs, and the purpose of the exercise is to help explore differences. The trainers must remain neutral throughout the exercise and maintain a balance between the different viewpoints presented. To cover the range of perspectives, the trainers will need to limit each group's responses to just two or three per statement.

Activity 6: Discussion *(15 minutes)*

1. Ask the participants the following questions:
   - Does everyone in the group have the same attitudes, or are there differences?
   - Which statements caused the widest range of disagreement? What could explain these differences?
   - Were any of the results surprising? Which ones?
   - How did it feel to talk about an opinion that was different from that of some of the other participants?
   - How do you think people's attitudes about the statements might affect the way in which they deal with men and women in their lives?
   - How might these attitudes be expressed to clients, and how might that make clients feel?

TRAINING TIP

The following are examples of how values and attitudes can negatively influence the quality of care:

- Not offering a client family planning counseling because we assume that she is no longer fertile or will no longer be having sex
- Not discussing a woman's desire for future pregnancies because we think that women who have had an obstetric fistula repaired should no longer give birth
- Alienating women and potentially jeopardizing the likelihood that they will seek care, by:
  - Implying that the woman is responsible for the obstetric fistula because she gave birth with a traditional birth attendant and did not go to a health facility or hospital
  - Expressing surprise that a young girl has suffered an obstetric fistula because, after all, she is just a girl and she was married too early
- Not including husbands/partners in care for women with fistula because we think they are partly to blame or because we think women are so embarrassed about the fistula that they will not want to talk about the problem with anyone

Refer to page 35 of the traumatic fistula supplement for several additional examples of how values and attitudes can negatively influence the quality of care.

2. Summarize the exercise by reviewing ways in which providers' values and attitudes can influence health care service delivery and by noting their responsibility to provide health care in a respectful and nonjudgmental manner.

TRAINING TIP

Sample Summary of Activities 5 and 6
(for the trainer to read to the participants)

"Many of you are from similar backgrounds, but you had very different responses to the statements. People's different experiences lead them to different conclusions. Being aware of our own attitudes helps to ensure that we do not impose our beliefs on our clients. We have a professional obligation to provide health care, including care for women with obstetric fistula, in a respectful and nonjudgmental manner."

Activity 7: Group Exercise *(45 minutes)*

1. Tell the participants that they will now focus on common myths or rumors about fistula. Facilitate a brainstorming session by asking the participants to identify rumors or myths that they have heard about fistula. The rumors or myths can relate to the causes of fistula, reasons why certain women develop fistula, or reasons why some women who develop fistula do not seek care. If the participants find it difficult to list myths, prompt them with some of the statements contained in Participant Handout 2-I.
2. As the participants identify myths, record them on the prepared flipchart entitled "Myths about Fistula." *(5 minutes)*
3. After the participants have identified a variety of myths or rumors, divide them into small groups of three or four people.
4. Instruct the small groups that for each myth identified by the group, they should develop accurate and simple responses or explanations that could be used during information-sharing activities (e.g., community outreach, faith-based events, women's groups, and meetings with influential persons). *(15 minutes)*
5. Reconvene the larger group and invite each small group to present their explanations. *(5 minutes for each group)*
6. Once all of the groups have presented, discuss this exercise by asking the following questions: *(10 minutes)*
    - How and why are myths invented and why do they spread?

      Possible responses:
        - Myths often stem from lack of knowledge and fear, and they are spread like gossip.
        - As myths are passed from person to person they often become distorted, resulting in rumors and misconceptions.
    - In what ways do myths play on people's fears and prejudices?

      Possible responses:
        - When people are unsure about a phenomenon (such as the cause of obstetric fistula), they might look for a culprit and unfairly accuse the person living with the problem of being the source of the problem.

- How do myths about fistula contribute to discrimination against women who have fistula?
- Were these explanations accurate? Would these explanations be understandable to persons without medical training?
- How can these myths affect a client's ability to seek care for treatment of fistula?
- Do health care providers sometimes believe these myths as well? Which ones? How would this affect their ability to work with clients?
- As part of a counseling session for women seeking care for fistula, how could you address clients' misconceptions about fistula while respecting their knowledge and beliefs at the same time?
- As part of a counseling session, how could you address family or community members' misconceptions about fistula while respecting their knowledge and beliefs?

Summarize the session's activities and close by reminding the respondents that health care providers must leave their values aside and treat clients in a nonjudgmental way.

TRAINING TIP

Depending on the background and knowledge of the group, there may be some confusion about the difference between facts and myths. The facilitator must help clarify any misconception among training participants while respecting their beliefs. One way of doing this is by asking the group to provide clarification or explanations of misconceptions and myths.

Essential Ideas

- Information about obstetric fistula can be distorted as it is passed from person to person, resulting in prevalent rumors or misconceptions. Fear, ignorance, shame, and other strong emotions can play a role in the emergence and perpetuation of myths, rumors, and misconceptions.
- Clients often have personal beliefs about obstetric fistula that providers have no way of knowing or understanding, unless they ask. Providers must find ways to provide accurate information while respecting clients' beliefs and not making them feel inferior.

Activity adapted from: EngenderHealth. 2002. *Integration of HIV/STI prevention, sexuality, and dual protection in family planning counseling: A training manual*. New York.

Session 2
Handouts and Resources

Participant Handout 2-A

Counseling, Informed Choice, Informed Consent, and the Rights of the Client

What Is Counseling?

Counseling is the process of helping clients confirm or make informed and voluntary decisions about their individual care. In most cases, counseling occurs in one-on-one sessions involving the client and the provider; it may also include the client's partner or another support person whom the client has requested to be present. Counseling is a two-way exchange of information that involves listening to clients and informing them of their options. Counseling should always be responsive to the client's individual needs and values. All providers, regardless of their professional background and educational credentials, need special training in counseling and informed choice.

What Is Informed Choice?

Informed choice is a voluntary, well-considered decision that an individual makes on the basis of options, information, and understanding of their situation. The process should result in a free and informed decision by the individual about whether he or she wants to obtain health services and, if so, what method or procedure he or she will choose.

What Is Informed Consent?

Informed consent is the communication between client and provider using simple language, terms and visual aids that the client understands, with the intention of confirming that the client has made an informed and voluntary choice to use or receive a medical method or procedure. Informed consent can only be obtained after the client has been given adequate and relevant information in language and terms she understands about the nature of the medical procedure, its associated risks and benefits, and other alternatives. Voluntary consent cannot be obtained by means of special inducement (incentive or disincentive), force, fraud, deceit, duress, bias, or other forms of coercion or misrepresentation.

Health care providers are often required by law or institutional policy to obtain informed consent before administering certain medical procedures, including experimental methods and procedures. Regardless of the presence or absence of written documentation, informed consent requires providers to ensure that a client receiving a method or treatment has knowingly and voluntarily agreed to be treated. Whether informed consent is written or verbal, however, it cannot replace the informed choice process, which is dependent on counseling and an exchange of information between providers and clients.

Informed and voluntary client consent is especially important before a medical procedure that has a permanent or long-acting effect or that requires the skills of a trained provider. To take an example from

family planning, voluntary sterilization is unique, in that it involves a surgical procedure to permanently end fertility. Therefore, many providers and funding agencies that support sterilization services specify the elements for informed consent and require written documentation of the client's consent. Although the purpose of informed consent should be to ensure the client's right to make a voluntary and informed decision, written consent is often required to provide evidence that the provider complied with informed consent requirements and to reinforce the importance of this client right.

Providers should also take special care to ensure informed decision making among women who have developed a fistula. These women are going through or have been through considerable medical, social, and emotional trauma and may have unresolved feelings about their condition.

What Are the Rights of the Client?

Clients have the right to:

- Information
- Access to services
- Informed choice
- Safe services
- Privacy and confidentiality
- Dignity, comfort, and expression of opinion
- Continuity of care

Adapted from: Huezo, C., and Diaz, S. 1993. Quality of care in family planning: Clients' rights and providers' needs. *Advances in Contraception* 9(2):129–139.

Participant Handout 2-B

Informed Consent in Fistula Care

This information sheet is a practical guide for program managers responsible for facilitating service delivery and for personnel providing direct care. This information is drafted to ensure that clients receiving fistula care give informed consent for procedures and/or surgeries (i.e., the primary surgery and any other that may become necessary in the course of the operation).

Fistula is a condition that few like to talk about, and the women living with fistula frequently feel shame at their constant leaking and odor. As a result, they often hide themselves or are forced to live in isolation from their communities—sometimes from their families. Because of the stigma and misunderstanding associated with this condition, women living with fistula are vulnerable to abuse and poverty, have limitations in caring for themselves and others, and may not have had access to education. Counseling a woman with these challenges requires openness, compassion, a willingness to simplify complex terms and concepts, and a genuine desire to make her feel welcome. Women living with fistula have the right to safe services, including access to accurate information about their condition, the range of treatment options, and posttreatment outcomes. Women living with fistula also have a right to be treated with respect, dignity, and consideration. Within these characteristics for quality, informed consent is a key element of care.

Informed Consent

Informed consent is the communication between client and provider using simple language, terms, and visual aids that the client understands, with the intention of confirming that the client has made an informed and voluntary choice to use or receive a medical method, procedure, or surgery. Informed consent can only be obtained after the client has been given adequate and relevant information in language and terms he or she understands about the nature of the condition, the causes, and the medical procedure, about its associated risks and benefits, and about alternatives. Voluntary consent cannot be obtained by means of special inducement (incentive or disincentive), force, fraud, deceit, duress, bias, or other forms of coercion or misrepresentation—including unwarranted deferral or repeated postponement of surgery.

The fact that the client signs a consent form does not necessarily mean that the person requests the procedure with full knowledge of the facts.

Informed Consent Process

Informed consent is not counseling. Counseling is the process by which service providers help ensure that a client makes an informed and well-considered decision about the fistula treatment procedure(s). ***Counseling is defined*** as a two-way communication process of helping clients make informed and voluntary decisions about their individual care. Counseling occurs in a one-to-one interaction involving the client and the provider; it may also include the client's partner or another support person whom the client has requested to be present. Through counseling, providers:

1. Give information the client needs to make a fully informed decision about fistula-related treatment
2. Determine whether the client understands the consequences of her own decision and is comfortable with it.

Documenting informed consent is one component of the counseling process designed to safeguard the client's right to make an informed decision; it also complies with legal requirements.

NOTE

Remember:
Counseling is the process; an informed decision is the intended outcome.

Five Elements of Informed Consent

1. **Treatment options:** Describe the treatment options in general terms; provide a brief description of the procedure indicated for the client; explain whether that particular procedure can be carried out within the facility or if the client must be referred; describe the costs that will be associated with the treatment (e.g., transportation, follow-up visits, etc.).
2. **Procedure details:** Describe in understandable details, using language the client understands and visual aids that the client can follow:
   - The type of surgery or procedure to be performed, and whether it will be one or (potentially) multiple surgeries, including the type of anesthesia to be used
   - The benefits of the procedure
   - A brief mention of the risks
   - An explanation of pain management
   - The anticipated postoperative course
   - Follow-up, including the need to practice sexual abstinence for a time and family planning afterwards
   - The possibility of failure or residual postoperative side effects.
3. **Associated risks:** Provide understandable details of the risks associated with any surgical procedure (e.g., complications, bleeding, infection, and death) and the risks associated with fistula repair (e.g., damage to nearby organs). Client may experience infertility, which may or may not be a result of the surgery.
4. **Potential outcomes:** Inform the client that she will no longer have leaking and associated discomfort once the test-of-cure assessment indicates the absence of leaking. (However, be sure to remind her that incontinence or continued leaking following surgery is also a potential outcome of the procedure.) Fertility may become an issue to address before complete healing takes place; therefore, there will be a need to protect the repair through a period of abstinence and a period of family planning use. In a few cases, the vagina may narrow after repair and the woman may experience pain when she has sex (dyspareunia) with a partner; this problem may require further care, and some cases the couple will have to adjust to living with it. Successfully repaired clients will need to abstain from sexual

intercourse for a period of time to allow for adequate healing; use family planning to safely space desired pregnancies; and obtain close antenatal care and monitoring and cesarean section delivery from skilled providers. For clients who have completed their childbearing, family planning should be used to prevent unintended pregnancy. As with all surgical procedures, some repair attempts may not be successful and may require further surgeries. In particular, with complex cases, it may not be possible to repair the fistula at all. In such cases, the client and family members will need to be guided as to the options of living with the condition.

5. **Options to decide for or against the procedure:** If the client decides to have the procedure, confirm her understanding of the procedure, benefits, risks, and potential outcomes; of the need for a period of abstinence for a period of time postrepair, followed by the use of family planning. If the client decides not to have the procedure, confirm that she has understood the other options available to her. Assure the client that she will not lose any health benefits she used to receive before and that she can still have the repair anytime she changes her mind.

Responsibility for Informed Consent

The director or administrator of the facility for fistula care is responsible for ensuring that informed consent is obtained and documented for every client who undergoes fistula repair. These senior personnel are responsible for ensuring that:

- Staff responsible for counseling and documenting informed consent are appropriately trained.
- A written protocol on informed consent is available to project staff.
- Adherence to informed consent procedures and principles is monitored regularly.
- An adequate supply of the approved informed consent form is available.
- The informed consent procedures at the service site comply with policies and procedures agreed upon with the national or international funding agencies, if any.

Informed consent can be obtained and documented by counselors, clinical officers, nurses or midwives, physicians, or administrative staff or volunteers *after they have been successfully trained in how to obtain and document informed consent*. However, the primary responsibility for ensuring that informed consent has been obtained is with the operating provider. The operating provider should also be the person accepting referrals from the staff where clients' questions or unresolved clinical issues arise.

NOTE

In some settings, administrative or nonmedical personnel may begin the counseling process, and the physician obtains and documents the client's informed consent. The person who obtains the informed consent after the counseling process has been started must be trained to assess whether the client's knowledge is complete and her decision is informed.

Informed consent should be **obtained** and **documented** *before* the procedure; documentation is made *after* the counseling process and *after* the person conducting the counseling determines that the decision has been made with a full understanding of the facts.

Informed consent should be obtained by following the Informed Consent Protocol (Participant Handout 2-C) and by reading the entire informed consent form aloud to the client. If the client can read, she should have a form to read along with the counselor. If the client cannot read, the witness should have a form to read along with the counselor. If the witness also cannot read, he or she should at least be present when the form is read aloud to the client. After asking if the client understands the information on the form and she requests the procedure, the counselor must then obtain the required signature or marks.

The informed consent form and the entire counseling process should be communicated in a language and in terms understood by the client. In setting where clients speak many different languages, staff responsible for counseling should speak the language that most of the clients use, so that the largest number may be served. Where counseling staff do not speak the client's language, an interpreter should be available to ensure that the client understands the informed consent counseling. (*Note:* This interpreter should be oriented to the philosophy and language of informed consent to help ensure consistency and quality of care.)

Informed consent forms should be available in the most common language and, to the extent possible, in other languages.

- For clients who can read and write, the informed consent form must be signed by the client and by the operating physician or his or her designated assistant.
- For clients who cannot read or write, the informed consent form must be signed by the client using a thumbprint or mark and by the operating physician* or his or her designated assistant. In such cases, it is advisable for the client to have a witness (e.g., a support person of her choosing) present during counseling, to ensure recollection of information. The witness should also sign the consent form in the designated area.

Each signature must be dated, and the date of each signature must be before or on the day of the surgery.

Management and Supervision of Informed Consent Compliance

The informed consent form should be part of the client's medical-surgical record and must be kept on file at the service delivery site after the fistula repair either for at least 3–5 years or for whatever the national medico-legal guidelines call for—whichever is longer.

The director or administrator of the facility is ultimately responsible for ensuring compliance with informed consent policies and procedures. Responsibility may be delegated to supervisors of staff implementing informed consent procedures. Compliance should be verified by chart review, observation of informed consent counseling, and interviews with clients.

* The operating physician or his or her designated assistant signs the consent form to indicate that he or she has verified the client's signature, thumbprint, or mark and has established that the client for fistula repair understands and agrees to undergo the surgery.

Chart review

Informed consent forms should be audited regularly; such audits should not be announced beforehand. The person conducting the review should have direct access to all records and should select those to be examined.

NOTE

Objective review of the forms should be guided by use of the following questions:

- Are staff members using the approved informed consent form?
- Does the form being used comply with the program's guidelines?
- Is there an informed consent form on file for each client who has undergone fistula repair procedures?
- Is the form correctly signed and dated?

The reviewer should look for the following indications that standard informed consent procedures are not being followed:

- The client's signatures on a number of forms are dissimilar (indicating possible forgery).
- The handwriting of the various signatures on a number of forms looks similar (indicating possible forgery).
- A signature appears on the form, even though it is inappropriate to the setting.

Observation of informed consent counseling

Observation of informed consent counseling should be a part of the quality improvement monitoring process on site. Immediately before counseling, staff should obtain the client's permission for the observation. The supervisor should verify that staff members are following informed consent policies and procedures. If deficiencies are noted, the supervisor should determine if the staff have copies of the informed consent protocol and are familiar with it. Where necessary, staff should be coached or retrained.

Interviews with clients

Client interviews may be conducted between documentation of informed consent and surgery. The objective is to verify that the client was informed fully (consistent with the elements of informed consent). The interview should be conducted using an established list of questions and within a reasonable time after counseling, to minimize the potential for the client to have forgotten information.

Adapted from: Butta, P. 1988. *Informed consent and voluntary sterilization: An implementation guide for program managers*. New York: Association for Voluntary Surgical Contraception.

Participant Handout 2-C

Fistula Care: Informed Consent Protocol

- Set up a counseling area that can provide auditory and visual privacy.
- Collect job and visual aids that will be used during the counseling session, including the informed consent forms.
- Put the woman at ease and ask what she knows about her condition and the fistula treatment that is being proposed.
- Correct any misinformation and fill in any knowledge gaps.
- If the woman will have a specific fistula procedure or surgery, conduct the informed consent counseling, using simple language to cover the **Five Elements**:
  - Provide general information about fistula and about fistula treatment, including procedures and surgeries, using visual aids to illustrate what you are saying;
  - Describe in detail the specific procedures or surgery that will be carried out, as well as information on anesthesia, benefits, risks, pain management, postoperative course and follow-up, including abstinence, family planning, and the woman's need to protect herself from becoming infected with HIV and other sexually transmitted infections
  - Communicate the associated risks of any surgical procedure (complications, bleeding, infection, infertility, and death) and any risks specific to fistula repair (damage to nearby organs)
  - Explain the procedure's outcomes, such as no longer having leaking, soiling, or both; its potential affect on sexual relations and the possibility of pain with sexual intercourse (in a few cases); the fact that future desired fertility cannot be guaranteed; that additional surgery may be needed during or after the repair; and the possibility of continued leaking despite the surgery
  - Inform the women that she can choose to decide for or against the procedure, that she can decide not to have the procedure without penalty or loss of benefits, and that she may have the repair if she changes her mind
- Allow the woman to ask clarifying questions and reply.
- Confirm that the woman understands by asking her to explain in her own words what will be done and what are the risks, possible outcomes, the potential impact on sexual relations and future fertility, the chance that additional surgery will be needed, and the options to not have the surgery or to have it at a later time.

- Introduce the informed consent form and read through it. If the woman agrees to the procedure, follow the instructions on the form for obtaining her signature (and that of a witness, for a woman who cannot read or write).
- Document the informed consent counseling in the client record.
- Insert the signed form into the client record.
- Inform the operating physician or his or her designate so that he or she signs the same form.
- Follow the facility's general preoperative protocols.

Participant Handout 2-D

Fistula Care: Informed Consent Form

Instructions: Read through the form with the client and print the client's full name in the space provided on the first line below. Ask client to put her initials in the space provided before each number after reading the statement. Ask the client to sign with her full name on the line for signature. Follow the instructions for signature of a witness. Ask the physician or his or her designate to sign this form before preoperative preparations begin.

I, _____ the signed, request that a fistula repair
(client's name)
surgery be performed on my person.

I make this request of my own free, informed will, without having been forced, pressured, or given any special inducements. I understand the following:

_____1. The procedure to be performed on me is a surgical procedure, the details of which have been explained to my understanding.

_____2. This surgical procedure involves risks of complications, such as bleeding, injury to other organs, and infection, including death.

_____3. This procedure offers the benefits of eliminating the fistula and its associated symptoms of leaking, soiling, or both.

_____4. No surgical procedure can be guaranteed to work 100% on all people; there is a potential for the procedure to fail; there also may be a need for additional surgery, or additional surgery may not be an option.

_____5. This surgical procedure will not guarantee future desired fertility.

_____6. The requirements for a successful outcome of this surgical procedure include a period of abstinence (3–6 months postrepair), followed by the use of family planning for a period of time before any attempt to conceive.

_____7. I can decide against the procedure at any time before the operation is performed (and no medical, health, or other benefits or services will be withheld from me as a result).

_____

(Signature or mark of the client) Date

_____

(Signature of attending physician/delegated assistant) Date

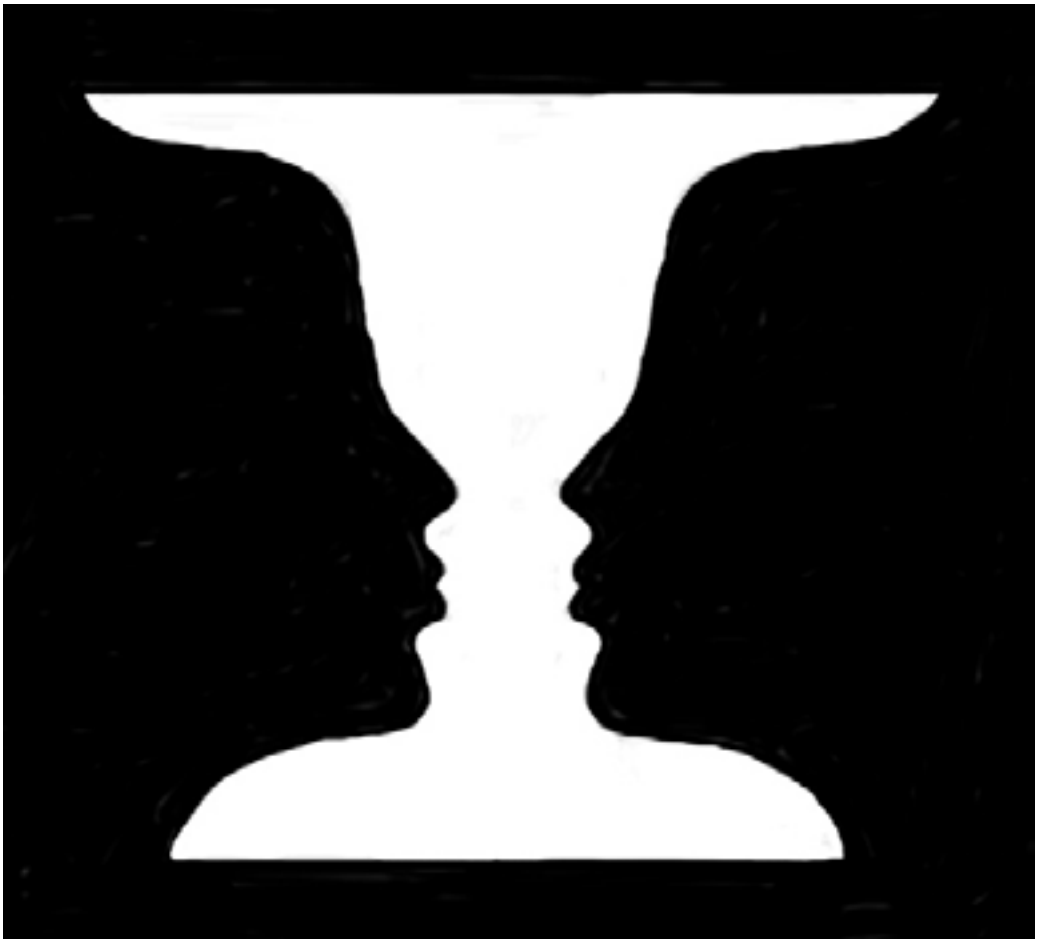
If the client cannot read, a witness of the client's choosing, and speaking the same language must sign the following declaration:

_____

(Signature or mark of witness) Date

Participant Handout 2-E

Ambiguous Figure



Participant Handout 2-F

The Gender Game

Identify if the statement refers to gender or sex.

Gender	Sex	
		1. Women give birth to babies; men do not.
		2. Girls should be gentle; boys should be tough.
		3. Globally, women or girls are the primary caregivers for those suffering from fistula in more than two-thirds of households.
		4. Women can breastfeed babies; men can bottle-feed babies.
		5. Many women do not make decisions with freedom, especially regarding sexuality and couple relationships.
		6. The number of women with HIV (human immunodeficiency virus) infection and AIDS (acquired immunodeficiency syndrome) has increased steadily worldwide.
		7. Four-fifths of all of the world's injecting drug users are men.
		8. Women get paid less than men for doing the same work.

Participant Handout 2-G

Gender

Gender refers to a set of qualities and behaviors that society expects a woman or a man to possess. Gender roles are learned and can be affected by factors such as education or economics. They vary widely within and among cultures. Although an individual's sex generally does not change, gender roles are socially determined and can evolve over time.

Gender roles and expectations are often identified as factors hindering the rights and status of women, with adverse consequences that might affect family life, education, socioeconomic status, and health. For this reason, awareness of gender, like awareness of sexuality, plays an important role in the provision of services for women with fistulas.

Below are some examples of gender-role stereotypes and beliefs that can affect the experience of fistula clients:

- Women should get married early to ensure that they are virgins.
- Men may demand to have sex with their wives or partners whenever they choose, regardless of a woman's desire to have sex or any medical proscriptions.
- Women do not enjoy sex and do not experience sexual desire; therefore, they would have no difficulty remaining abstinent after a surgical fistula repair.
- Men demonstrate their virility by having sex frequently and with many partners.
- Women who are not genitally cut are sexually promiscuous.
- Men know what is right for their wives, and women should follow their directives, even with regard to seeking health care.
- Women who were raped were probably asking for it.
- Women never have a need for sex.

Discussion Points

If providers believe that women develop obstetric fistula because they give birth at home with a traditional birth attendant and that they therefore are somehow responsible for their condition, then the providers might be less sensitive to their clients' feelings and needs.

Examine the relationship between gender roles and power, and acknowledge that in some cases women are able to choose neither whether they engage in sexual activity nor whether they use a family planning method.

The experience of becoming pregnant as a result of male coercion, force, or dominance can make clients distrust male providers. In such cases, fistula clients might be reluctant to ask questions or express concerns.

Participant Handout 2-H

Values and Attitudes in the Provision of Health Care Services

A *value* is a belief that is important to an individual. Values can be influenced by religion, education, culture, and personal experiences.

Our values shape our *attitudes*. An *attitude* is the way we think about and act toward particular people or ideas.

Every interaction between a woman and the health care staff—from the time she enters the health care system until she is discharged—affects the woman's satisfaction with her care, how quickly she recovers, and how well she takes care of herself after she leaves the facility.

The way we communicate our own values and attitudes (both verbally and nonverbally) is an important part of our interactions with the people we treat. Our values are often so ingrained that we are unaware of them until we are confronted with a situation that challenges them.

Our values, attitudes, feelings, and biases will affect how we treat a client's condition. For example, our private reaction to the way the client looks or smells, to her social class, or to her reason for treatment might affect the way we provide care, the gentleness or harshness with which we perform procedures, the delay that we may impose, and whether we consider the full range of her health care needs.

Participant Handout 2-I

Sample Myths and Misperceptions about Fistula

In many countries where fistula is prevalent, cultural beliefs and practices shape a client's ability and desire to seek medical services. Although some community members might correctly recognize prolonged obstructed labor as the cause of obstetric fistula, they might attribute the length of labor, the fact of its not progressing, and/or ultimately the development of fistula to a variety of other causes, many of which are believed to be linked to the woman's personal and/or social characteristics or behaviors. Many community members are not aware that sexual violence can result in a fistula. Myths and misperceptions can play a role in lack of fistula prevention, unwarranted stigma and discrimination, and poor access to treatment. Targeted counseling can play a key role in dispelling the myths or misperceptions that clients and their families have about why fistula occurs and how it can be treated and prevented.

Myths and misperceptions about the origin of fistula vary depending on cultural context. Below are some examples of beliefs that a woman (or others in her community) might have about why she developed a fistula:

- She had an affair with a man who is not her husband.
- She came under a "spiritual attack" because she did not give birth under the care of a person who had the ability to protect her spiritually.
- Witchcraft was performed against her by others jealous of her (perhaps due to her economic status or because she had many children).
- A traditional birth attendant or provider at a health facility pinched her bladder during labor or delivery.
- She had a sexually transmitted infection.
- She or her mother offended the spirits during pregnancy.
- She was a young girl married to an older man.
- She was cursed by her parents for getting pregnant before marriage.
- She failed to pay her dowry and was punished as a result.
- She tried to abort her baby while she was pregnant.

Other cultural beliefs and practices that might contribute to the incidence and prevalence of fistula include the following:

- Some societies expect a woman to have a natural birth; if she cannot, she is a considered a coward or "not woman enough."
- In some societies, a woman is expected to deliver her first-born child at home. Such practices might prevent a woman from going to a facility, even when labor complications arise.
- Based on her religion, a woman might feel that she must accept the fistula as her destiny and that she should live with it for the rest of her life. She might believe that her suffering will be rewarded in heaven and that therefore she should not seek treatment.

Adapted from: The ACQUIRE Project and EngenderHealth. 2005. *Report of fistula counseling experts' meeting: March 29 & 30, 2005, Kampala, Uganda*. New York.

Trainer's Resource 2-A

Fistula Care Informed Consent Exercise

Answers to these questions can be found in Participant Handout 2-B.

1. "Informed consent" is defined as: _____
   _____
   _____

2. True/False: If the client signs the consent form for fistula repair surgery, it means that the person willingly and with full knowledge of the facts has requested or agreed to have the procedure.

3. What five elements must be covered for informed consent in fistula care services?
   1). _____
   2). _____
   3). _____
   4). _____
   5). _____

4. Who is responsible for carrying out the informed consent process? _____
   _____

5. What is necessary for the informed consent process to be functional? _____
   _____

6. Who can obtain informed consent for fistula care procedures? _____
   _____

7. When is the best time to obtain informed consent? _____
   _____

8. How should informed consent be carried out?_____
   _____

9. How should informed consent be carried out with clients who cannot read or write? _____
   _____

10. True/False: Assessing compliance to the informed consent process requires only reviewing charts to ensure that the forms have been signed and dated correctly.

Trainer's Resource 2-B

Answers to the Gender Game

Gender	Sex	
	X	1. Women give birth to babies; men do not.
X		2. Girls should be gentle; boys should be tough.
X		3. Globally, women or girls are the primary caregivers for those suffering from fistula in more than two-thirds of households.
	X	4. Women can breastfeed babies; men can bottle-feed babies.
X		5. Many women do not make decisions with freedom, especially regarding sexuality and couple relationships.
X	X	6. The number of women with HIV (human immunodeficiency virus) infection and AIDS (acquired immunodeficiency syndrome) has increased steadily worldwide.
X		7. Four-fifths of all of the world's injecting drug users are men.
X		8. Women get paid less than men for doing the same work.

Trainer's Resource 2-C

Examples of Flipcharts for "Act Like a Man" and "Act Like a Woman"

Act Like a Man:

- Be tough.
- Do not cry.
- Yell at people.
- Show no emotions.
- Take care of other people.
- Do not back down.

Act Like a Woman:

- Be passive.
- Be the caretaker.
- Act sexy, but not too sexy.
- Be smart, but not too smart.
- Be quiet.
- Listen to others.
- Bear pain

Trainers' Resource 2-D

Sample Values Statements

These are values that individuals may have regarding fistula or women with fistula.

Countries have a responsibility to provide free care to all women with fistula.

Women who are not educated are more likely to get fistula.

Women who have had genital cutting are more likely to get fistula.

If a woman with fistula had taken care of herself, she would not have so many health and social consequences from fistula.

All women should be assisted in reaching their fertility goals after the successful repair of a fistula.

The only way to prevent obstetric fistula is by ensuring that all women give birth in a hospital or health center.

Obstetric fistula is mostly the result of poverty and poor access to health services.

Fistula can be caused by rape or sexual violence.

Most fistulas are caused by traditional birth attendants who do not respect recommendations for referral during prolonged labor.

Women with fistula will have a hard time being reintegrated into their communities, so governmental and nongovernmental organizations should fund projects that let these women live together in their own fistula community.

Any woman who has a fistula repaired should be sterilized to avoid subsequent damage to the surgical repair.

Early marriage is part of traditional society, and there is little or nothing that can be done to change this institution.

Traditional birth attendants and service providers in health facilities need to collaborate to prevent obstetric fistula.

Men who abandon their wives because their wives have fistula should be punished under the law.

Many obstetric fistulas are caused by traditional birth attendants who perform acts that damage the woman's reproductive tract.

Obstetric fistula affects a small percentage of women, and given the limited budgets for health care, money should be invested in preventing obstetric fistula rather than in trying to treat those who already have it and are probably accustomed to it.

The only way to reduce the number of women with obstetric fistulas is to work with communities to mobilize them around issues like early marriage and health-seeking behavior for women.

Session 3
Understanding Obstetric Fistula

Refer to pages 38 through 40 of the traumatic fistula supplement for alternative Session 3 Overview—Session Objectives, Points to Remember, and Training Methods, and Advance Preparation.

Session Objectives

During this session, the participants will:

- Define obstetric fistula
- Describe the experience of women with obstetric fistula
- Describe the etiology of, contributing factors to, and consequences of obstetric fistula
- Describe the three elements of a comprehensive strategy for the prevention of obstetric fistula

POINTS TO REMEMBER

- ✓ An ***obstetric fistula*** is an abnormal passage or opening between the genital tract and the urinary or intestinal tract.
- ✓ There are many types of fistula, but the large majority are *vesicovaginal fistula* (VVF). After VVF, the most common types of fistula are combined VVF and *rectovaginal fistula* (RVF).
- ✓ In developing countries, the predominant cause of obstetric fistula is prolonged, obstructed labor and lack of prompt access to emergency obstetric care.
- ✓ The most important underlying social causes of obstetric fistula are lack of access to quality obstetric care, including the presence of a skilled attendant during labor and delivery, and lack of access to critical family planning services.
- ✓ Lack of access to care is often associated with early marriage or early childbearing, poverty, malnutrition, compromised women's rights, and lack of equity.
- ✓ Obstetric fistula has a wide range of adverse medical and social consequences. "The understanding that one must treat the 'whole person' with the fistula—not just her injured bladder or rectum—is the single most important concept in fistula care," writes Lewis Wall.

— Wall, L. L. 1998. Dead mothers and injured wives: The social context of maternal morbidity and mortality among the Hausa of northern Nigeria. *Studies in Family Planning* 29(4):341–359

(continued)

POINTS TO REMEMBER *(continued)*

- ✓ Many factors prevent poor, isolated women from seeking help, but when high-quality surgical repair is made available to them, their demand for services increases greatly.
- ✓ Three elements form the core of a comprehensive approach to preventing obstetric fistula:
  - Improving access to obstetric care, including emergency care
  - Delaying early pregnancies
  - Addressing social issues

Training Methods

- Warm-up
- Small-group exercise
- Discussion
- Presentation

Materials

- Flipchart paper, easel, markers, and tape
- Overhead projector (optional)
- Participant Handout 3-A: Description of the Problem of Obstetric Fistula
- Participant Handout 3-B: Causes of Obstetric Fistula
- Participant Handout 3-C: Health and Social Consequences of Obstetric Fistula
- Participant Handout 3-D: Reasons Why Women Do Not Seek Care
- Participant Handout 3-E: Prevention of Obstetric Fistula
- *(Optional)* Participant Handout 5-E (*use as transparency*): Four Common Types of Obstetric Fistula
- Participant Handout 5-F (*use as transparency*): Prolonged Labor and Its Effect on the Reproductive Tract

Advance Preparation

1. Prepare a flipchart listing the objectives of this session.
2. Review all handouts and make one copy for each participant.
3. Review the training strategy and training tips for the session.
4. Prepare flipcharts or transparencies for presentations.

Session 3 Training Steps

Session Time (total): 1 hour, 35 minutes

PART A: DESCRIPTION OF THE PROBLEM

Time: 20 minutes

Activity 1: Warm-Up *(5 minutes)*

1. Review the objectives for this session.
2. Write the following statements on a flipchart or transparency (or simply hand out pieces of paper, read the statements aloud, and ask the participants to write down whether they think each statement is true or false. Tell the participants that you will ask for the correct answers at the end of this section.

Refer to page 41 of the traumatic fistula supplement for an alternative list of statements that can replace the one in this curriculum.

Statement	Response
It has been estimated that, worldwide, fistulas occur in one or two of every 1,000 deliveries.	True
The great majority of fistulas are rectovaginal.	False
In general, women with fistula are very poor and lack the means to get to a health facility in time to receive emergency obstetric care.	True

Activity 2: Presentation/Discussion *(5 minutes)*

1. Present a brief description of the fistula problem globally, based on Participant Handout 3-A.
2. Ask one or two participants to comment on how prevalent they feel the problem is in their community. Compare this to global data.
3. Present the content on types of obstetric fistula, using Participant Handout 3-A.
4. Distribute Participant Handout 3-A to the participants.

TRAINING TIP

Consider using a transparency of Participant Handout 5-E: Four Common Types of Obstetric Fistula to more clearly explain the anatomy of the various obstetric fistulas.

Refer to pages 42 through 45 of the traumatic fistula supplement for Supplemental Handout 3-a to present and distribute during this activity.

Activity 3: Brainstorm *(5 minutes)*

1. Ask the participants to brainstorm the characteristics of a "typical" obstetric fistula client. Write their answers on a blank piece of flipchart paper. If necessary, complete the list after the group has exhausted their ideas.

TRAINING TIP

The profile of a "typical" fistula client should include age when the fistula occurred, age when the woman came to a repair facility, parity, socioeconomic status, educational level, and cause of the fistula.

Building a profile of a typical fistula client assists program managers and providers in understanding and caring for women with fistula. However, it is important to point out that while some similarities exist among fistula clients in the communities where the participants work, they will find both that each woman's situation is unique and that a few clients will be atypical (e.g., women in their late 30s who have delivered five or more times).

Refer to page 47 of the traumatic fistula supplement for Part A, Additional Activity 4.

PART B: CAUSES OF OBSTETRIC FISTULA

Time: 15 minutes

Activity: Presentation/Discussion *(15 minutes)*

1. Explain the difference between direct and indirect causes of obstetric fistula. Distribute Participant Handout 3-B and briefly review the direct and indirect causes of obstetric fistula. Use Participant Handout 5-F as a transparency to help illustrate how prolonged labor can cause obstetric fistula.

2. Ask for one or two volunteers to explain in lay terms how prolonged labor can lead to an obstetric fistula.
3. Allow time to respond to the participants' questions.

TRAINING TIP

Understanding the direct and indirect causes of obstetric fistula is essential to understanding prevention. Providers must have a good grasp of the causes of fistula if they are to adequately and simply explain them to clients and their families.

Refer to pages 48 through 51 of the traumatic fistula supplement for Supplemental Handout 3-b to present and distribute during this activity.

PART C: HEALTH AND SOCIAL CONSEQUENCES OF OBSTETRIC FISTULA

Time: 20 minutes

Activity: Small-Group Work *(20 minutes)*

1. Divide the participants into two groups, one to discuss social consequences and the other to discuss health consequences of fistula.
2. Ask the two groups to spend five minutes developing a list of consequences. Have one participant from each group present their list to the larger group.
3. After each small group has completed its presentation, ask the larger group to comment or make additions to what has been presented.
4. If necessary, supplement the lists after all of the groups have presented their results.
5. Distribute Participant Handout 3-C to the participants.

Refer to pages 52 through 54 of the traumatic fistula supplement for Supplemental Handout 3-c to discuss and distribute during this activity.

Refer to pages 55 and 56 of the traumatic fistula supplement for Part C, Additional Activity 2 and Supplemental Handout 3-d to present and distribute during this activity.

PART D: REASONS WHY WOMEN DO NOT SEEK CARE

Time: 20 minutes

Activity: Large-Group Work *(20 minutes)*

1. Ask the participants to brainstorm a list of reasons why women do not seek care when they have a fistula.
2. Record the participants' responses.
3. Review the participants' responses; if necessary, supplement the lists.
4. Distribute Participant Handout 3-D to the participants.

Refer to page 57 of the traumatic fistula supplement for Part D, Additional Points to Discuss.

PART E: PREVENTION OF OBSTETRIC FISTULA

Time: 20 minutes

Activity: Small-Group Work *(20 minutes)*

1. Divide the participants into two groups, one to discuss prevention of direct causes of obstetric fistula and one to discuss prevention of indirect causes. Be sure to explain clearly the difference between direct and indirect causes.
2. Ask the groups to spend five minutes developing a list of ways to prevent obstetric fistula and challenges to their preventive interventions.
3. Have one participant from each group present their group's list.
4. After each group has completed its presentation, ask the larger group to comment on or make additions to what has been presented.
5. If necessary, supplement the lists after both groups have presented their results.
6. Distribute Participant Handout 3-E to the participants.
7. Ask the participants how knowledge about the incidence and prevalence, demography, causes, consequences, and prevention of fistula will help them provide quality counseling services for women with fistula.
8. Provide the participants with answers to the questions asked at the beginning of the session.
9. Allow time to respond to the participants' questions.

Session 3 Handouts

Participant Handout 3-A

Description of the Problem of Obstetric Fistula

Global Data

How widespread is obstetric fistula? Fistulas are estimated to occur in one or two cases per 1,000 deliveries worldwide (two to three cases per 1,000 deliveries in areas with high maternal mortality, where access to emergency obstetric care is limited) (UNFPA, 2003). The actual prevalence of fistula, however, is not known. Prevalence rates vary widely, not only from country to country, but also from one region to another within the same country. More information about obstetric fistula will become available as organizations such as EngenderHealth conduct facility and community assessments to evaluate the exact magnitude in particular countries and worldwide.

Based on the number of women seeking treatment, the World Health Organization (WHO) has estimated that more than 2 million women have untreated obstetric fistula (UNFPA, 2003). However, this figure is thought to be an underestimate for many reasons, including that many women with fistula do not seek treatment.

Obstetric fistula appears to be most prevalent in Sub-Saharan Africa and South Asia. One study estimated that at least 33,450 new cases of obstetric fistula occur per year in rural areas of Sub-Saharan Africa, where emergency obstetric care is inaccessible or poor (Vangeenderhuysen, 2001). This estimate is much higher than estimates based on hospital reports. Obstetric fistula could also be widespread in parts of the Near East and North Africa, although the lack of studies precludes accurate estimates.

Obstetric fistula is rare in more developed countries because emergency obstetric care is readily available. Before the 20th century, however, obstetric fistula was common in Europe and North America. Then, as in many less-developed countries today, women often married and became pregnant at a young age, many were undernourished, few had adequate access to skilled birth attendants, and most lacked quality medical care.

Types of Obstetric Fistula

An ***obstetric fistula*** is an abnormal passage or opening between the genital tract and the urinary or intestinal tract. (The part of the genital tract that is most often affected is the vagina, but the uterus and/or the cervix also can be affected. In the urinary tract, fistula most often affects the bladder but can sometimes also affect the urethra or the ureter. Within the intestinal tract, the rectum is most affected.) This abnormal opening is usually the result of an injury incurred during delivery, most frequently from prolonged or obstructed labor. The constant pressure of the baby's head against the vaginal and bladder wall tissue cuts off the blood supply and leads to tissue *necrosis* (or death), which causes a fistula to develop. (For more information, see "Direct Causes of Fistula" in Participant Handout 3-B.) The fistula results in the uncontrolled passage of urine and/or feces into the vagina.

- A **vesicovaginal fistula** (VVF) is an opening between the bladder and the vagina. Urine from the bladder flows into the vagina, leading to total or continuous incontinence.
- A **urethrovaginal fistula** is an opening between the urethra and the vagina. Urine from the bladder flows into the urethra and then into the vagina, leading to total or continuous incontinence.
- A **ureterovaginal fistula** is an opening between the distal ureter and the vagina. Urine from the ureter bypasses the bladder and flows into the vagina. This also results in total or continuous incontinence.
- A **rectovaginal fistula** (RVF) an opening between the rectum and the vagina. Stool flows into the vagina, leading to passage of flatus or stool through the vagina, frequent vaginal or bladder infections, a foul-smelling vaginal discharge, or frank stool being passed out of the vagina.
- A **vesicouterine fistula** is a rare complication of vaginal birth after cesarean section. It is an opening between the uterus and the urinary bladder. Urine from the bladder flows into the uterus and then into the vagina, leading to total or continuous incontinence.

A large majority of fistula are of the VVF type. After VVF, the most common type of fistula is combined VVF/RVF. A small minority of fistulas are the RVF type and other types.

Who Develops the Condition?

Women with fistulas range in age from adolescents to older adults. Fistula is believed to be most common among young women and girls experiencing their first pregnancy (Wall, 1996). In regions where early marriage is the norm, young girls are particularly at risk. In young women who are not fully mature, the pelvis may be too small to easily withstand complicated childbirth. Older fistula clients generally have lived for several (or many) years with fistula, although some older women who have already had several children may develop an obstetric fistula if they have a malpresentation and difficult labor. Regardless of the reason for the obstructed labor, the reason for developing an obstetric fistula is lack of access to emergency obstetric care—most notably, a cesarean section, which is performed in emergencies to relieve the obstruction.

In general, women with fistula are very poor and may have lacked the means to get to a facility in time to receive emergency obstetric care. The vast majority have not had the benefit of formal education. Their nutritional status is generally low, and most live in remote, rural areas. Furthermore, their access to critical family planning services is often limited, and young women usually lack the social power to make choices for themselves about health care and pregnancy.

Sources

Bello, K. [no date given]. A selection of essays: Vesicovaginal fistula (VVF): only to a woman accursed. International Development Research Center. Retrieved from http://www.idrc.ca/en/ev-28382-201-1-DO_TOPIC.html, July 12, 2006.

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United Nations Population Fund (UNFPA). [no date given]. Campaign to end fistula. Retrieved from www.endfistula.org.

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Participant Handout 3-B

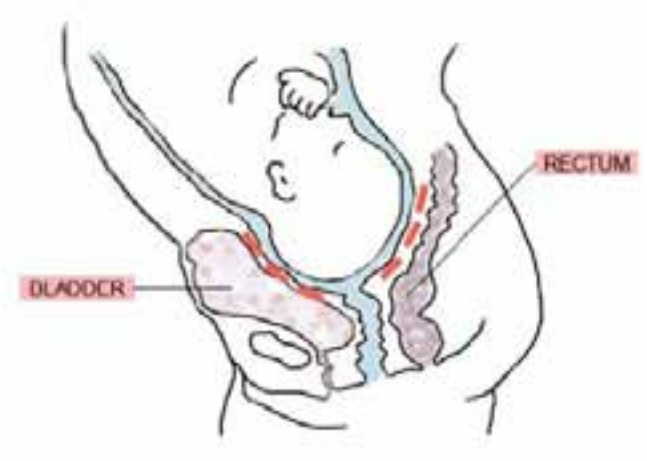
Causes of Fistula

Direct Causes of Fistula

The physical factors that influence the incidence of fistula include the following:

Obstructed Labor

In developing countries, the predominant cause of obstetric fistula is prolonged obstructed labor and a lack of prompt access to emergency obstetric care. During the prolonged labor, the soft tissues of the pelvis are compressed between the descending baby's head and the mother's pelvic bones. This unrelenting pressure of the entrapped fetal head against the mother's pelvis can cut off the flow of blood to the soft tissues of the bladder, vagina, and rectum. If the mother survives, prolonged obstructed labor usually ends with the death of the fetus, which is followed by the decomposition of the fetus to the point that it can slide out. Meanwhile, the lack of blood flow in the mother's pelvic area causes tissue to die and can create a hole between the mother's vagina and bladder (known as a vesicovaginal fistula [VVF]) or between her vagina and rectum (known as rectovaginal fistula [RVF]) or both.



Source: UNFPA. [no date given]. Campaign to end fistula. Retrieved from www.endfistula.org.

Accidental Surgical Injury Related to Pregnancy and Instrument Delivery

Fistula may be caused by injury to the bladder during obstetric operations performed within the modern health care system. Such procedures include cesarean sections, difficult forceps deliveries, injudicious vacuum extractions, or destructive vaginal deliveries (e.g., cleidotomy, or surgical division of the collar bones, for shoulder dystocia; cranial perforation for hydrocephalus; and decapitation for shoulder prolapse with intrauterine fetal demise). Fistula may also be the unintended result of episiotomy.

Other Direct Causes

There are also physical factors that influence the incidence of nonobstetric fistula, including:

- **Gynecological operations:** The majority of genital tract fistulas in developed countries are a consequence of gynecological surgery, malignancy, or irradiation.
- **Harmful traditional practices:** Traditional practices such as female genital cutting are thought to be associated with development of fistula, but this hypothesis requires further documentation. Female genital cutting is usually carried out under unsanitary conditions, often removing large amounts of tissue and possibly causing the vaginal outlet and birth canal to become scarred and constricted.
- **Trauma caused by rape or other sexual abuse:** Fistula caused by rape or other sexual abuse may be far more common than official statistics suggest, because many victims do not seek treatment if they lack access or fear stigmatization. In situations of war and civil unrest, in which rape is usually far more common, the proportion of fistulas caused by sexual abuse can increase substantially.
- **Symptoms of various diseases:** Rectovaginal fistulas also can be the result of various diseases, including infection by *lymphogranuloma venereum* or rectal carcinoma. They are rarely seen in association with diverticular disease of the bowel or Crohn's disease, or after radiotherapy treatment for cervical cancer.

Underlying Social Causes of Obstetric Fistula

The most important underlying social cause of obstetric fistula is a lack of access to quality obstetric care, including skilled attendance during labor and delivery. Access to health care may be hindered by any one or all of the following delays: (1) delays in deciding to seek care; (2) delays in reaching a health care facility; and (3) delays in receiving sufficient care at the facility. This lack of access is often associated with early marriage or childbearing, poverty, malnutrition, compromised women's rights, and lack of equity.

1. **First Delay: Delays in deciding to seek care:** Delays in deciding to seek care include both a woman's or her family's delay in seeking care from a skilled birth attendant and the attendant's delay in making the appropriate referral to an emergency obstetric care facility. Common contributors to such delay include cultural taboos, the low social status of women, a lack of knowledge and skills (including lack of understanding of the parameters for normal and abnormal pregnancy and labor and delivery), little or no preparation for birth or for possible complications, limited options for transportation, and lack of resources.

2. **Second Delay: Delays in reaching a health care facility:** It has been said that obstetric fistula results from a combination of obstructed labor and obstructed transportation. Even after a decision has been made to seek care, a woman might not reach a facility in time to receive emergency care.

3. **Third Delay: Delays in receiving attention at the facility:** The third delay can occur at the treatment facility itself. Many hospitals and clinics do not have enough skilled personnel to offer prompt surgical treatment for emergency obstetric cases. Emergency care might be delayed because supplies are lacking, diagnoses are late or wrong, actions are incorrect, or women cannot afford to pay for services (or there is no subsidy policy for emergency treatment) (Hinrichsen, 2004).

While the three delays represent the direct obstacles to receiving care, the following factors contribute to these delays.

- **Poverty:** Fistula clients tend to live in remote areas, to be impoverished, and to have little or no schooling—factors typically associated with inadequate health care during pregnancy and delivery and thus with increased risk for obstetric complications.
- **Poor access to health services:** With less access to obstetric care, rural women are more likely to suffer fistulas than are urban women. Even if a woman does not want to deliver at home, the physical barriers to seeking care are so great, and transportation is so limited, that it is often nearly impossible for her to deliver at a medical facility. In some cases, women distrust services provided within the health care infrastructure and so they would prefer not to seek care.

  The prevalence of untreated obstetric fistula appears to be closely associated with a lack of skilled assistance during delivery and a lack of access to emergency obstetric care, as well as to the shortage of capacity for fistula repair.
- **Early childbearing:** Although obstructed labor and obstetric fistulas can occur at any age during the childbearing years, adolescent women are at particular risk because childbearing before the pelvis is fully developed is a physiological factor that contributes to obstructed labor. In many traditional societies, marriage may occur before menarche and often is followed by early initiation of sexual intercourse and early pregnancy.
- **Malnutrition:** Many women have a contracted pelvis, most often as a result of malnutrition and increased infection rates in adolescence (and even in utero), leading to stunted growth and poor development. Occasionally, polio, rickets, or other bone- or gait-affecting diseases may play a part. This, compounded by the fact that women often marry young and begin childbearing before their growth is complete, partially explains the high prevalence of obstetric fistulas in the developing world.
- **Gender discrimination:** Because of their low social status in many communities, women often lack the power to choose for themselves when to start having children or where to give birth. Women often lack decision-making and economic power, even in decisions pertaining to their own health. Lack of power is a major determinant in the health-seeking behavior of women. For example, if labor becomes obstructed and all local methods fail, a woman may be taken to a hospital only if consent is given either by her husband or by her husband's surrogate (e.g., brother-in-law), the village chief, or, in some instances, her mother-in-law.

Sources

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Participant Handout 3-C

Health and Social Consequences of Obstetric Fistula

A fistula can be devastating. Not only does the afflicted woman often lose her baby, but the lasting physical consequences—including the constant leakage of urine, feces, or both, and the resulting odor—make it difficult, if not impossible, for her to lead a normal life. These medical consequences, coupled with social and economic problems, often contribute to a general decline in health and well-being that eventually results in early death. Some women with fistula commit suicide.

The wide range of adverse medical and social consequences has crucial implications for care. "The understanding that one must treat the 'whole person' with the fistula—not just her injured bladder or rectum—is the single most important concept in fistula care," writes Lewis Wall (1998).

Medical Consequences of Obstetric Fistula

- A certain percentage of women with fistula experience symptoms of perineal nerve injury, including foot drop. The *foot drop** results from excessive compression of the sacral nerve plexus by the fetal head. Damage to the perineal nerve can also result from laboring for days in the squatting position. The damage may be exacerbated by the application of pressure on the gravid abdomen by traditional labor assistants.
- Gynecologic sequelae are often the most noticed effects of obstructed labor.
- Damage to the pelvic sacral nerves to the legs leaves some women unable to walk, and they may need extensive physical rehabilitation that begins before surgery and is completed after treatment.
- Many women suffer nerve damage to the bladder, which results in complex bladder/ urinary problems.
- Dermatologic injuries in women who have vesicovaginal fistulas as a result of obstructed labor include vulvar excoriation and ammonical dermatitis, painful skin conditions resulting from continuous urine leakage.
- Some women experience dehydration due to drinking as little as possible to avoid leakage.
- Women may develop frequent ulcerations and infections, leading to kidney disease.
- Many women with fistulas are socially isolated and may not receive adequate nutrition or may be obliged to beg for food. Other women experience infection or hemorrhage at the time of birth and may suffer from anemia.
- Women who experience obstructed labor are more likely to suffer bone abnormalities, including bone resorption, fractures, bone spurs, and obliteration or separation of the symphysis.

* Foot drop is an extended position of the foot caused by paralysis of the flexor muscles of the leg; in women, it can be caused by obstructed labor.

- Pituitary and hypothalamic dysfunction possibly attributable to fistula may lead to amenorrhea.
- The genital tract may be scarred and lead to dyspareunia (pain during sexual intercourse).
- Women who have suffered through prolonged obstructed labor also have a higher risk of acquiring infections, including pelvic inflammatory disease.
- The combination of amenorrhea, pelvic inflammatory disease, and genital tract damage scarring results in a high rate of secondary infertility in these clients—a significant problem considering the importance placed on childbearing in most societies in the developing world.

Social Consequences of Obstetric Fistula

- **Stigma related to stillbirth:** The delivery of a stillborn (which occurs in up to 90% of cases of prolonged obstructed labor) is particularly distressing in societies that place a great emphasis on childbirth. The birth of a living baby is celebrated by a woman's family and community, whereas the woman who gives birth to a stillborn typically brings sorrow and shame to her family.
- **Subjection to myths and misconceptions about fistula:** The causes and consequences of obstructed labor are often misunderstood, and some believe that the problem is the work of evil spirits or the result of sexually transmitted infections (see Participant Handout 2-D).
- **Social isolation**
  - Women with fistula may be perceived as dirty, and thus they are often excluded, or they exclude themselves, from participating in community activities, including religious celebrations or public observances.
  - The incontinence and childlessness caused by prolonged obstructed labor and fistula sometimes lead to marital breakdown and eventually divorce.
  - In some cases, women with fistula are not permitted to live in the same house as their families or husbands; nor are they allowed to handle food, cook, or pray.
  - Women hospitalized for fistula repair might not receive as much care and support from their husbands as women receiving treatment for other conditions or illnesses, and the amount of practical support provided by family members usually diminishes over time.
  - In some cases, women with fistula feel they are a disgrace to their families and deserve to be outcasts. These women develop psychological self-labeling and self-esteem problems.
  - Facing familial and social rejection and unable to make a living by themselves, many women with fistula live for years without any financial or social support. Many fall into extreme poverty.
  - Some women cannot cope with the pain and suffering and resort to suicide.

Despite the stigma, many women with fistulas show remarkable resilience and strength. They find ways to be survivors, rather than victims; they support themselves and their children; and some manage to set money aside over many years so that they can seek fistula repair.

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Participant Handout 3-D

Reasons Why Women Do Not Seek Fistula Care

In 90% of uncomplicated cases, fistula can be surgically repaired (Hinrichsen, 2004). Women who receive appropriate treatment can go on to have children, usually by cesarean section. However, many factors prevent poor, isolated women from seeking help, including the following:

- **Lack of awareness of a possible cure**
- **Lack of access to health facilities due to distance, time, and cost:**
  - *Lack of local health facilities within easy reach.* Most hospitals are established in urban areas and many affected women live in remote areas that are far from clinics. People in rural areas are marginalized in terms of health provisions and infrastructure, including local health centers, good roads, and experienced health personnel. No or limited access to care or follow-up.
  - *Lack of financial resources.* The cost of fistula repair surgery is beyond the means of the very poor.
- **Low acceptance of modern health care, due to:**
  - *A difference in cultural and medical norms.* In medical facilities, women encounter behavior to which they are not accustomed.
  - *Low social status.* Women are treated without dignity or respect and, in some cases, are even verbally abused by medical staff.
  - *Bias among health facility staff; fear of maltreatment.* Women of certain ethnic, religious, or socioeconomic backgrounds may be discriminated against at health facilities and treated with disrespect and scorn.
  - *Lack of faith in modern health care.*
- **Inability of health facilities to adapt to caring for fistula clients:**
  - *Hierarchical organizational structure.* Hospitals often represent a hierarchical structure with rigid guidelines, and they are sometimes criticized as impersonal and inhuman. Most women coming for fistula repair services are not used to this kind of structure or to impersonal relationships.
  - *Failure to engage clients.* Hospitals might not have made efforts to encourage clients to participate in their own care. For example, because most hospitals have a very traditional hierarchy, staff may not consider asking clients about their needs. Yet a client may need to be informed that she will be in the hospital for an extended period of time and may need to make arrangements for things like child care. She might also be responsible during her postoperative stay for checking to make sure that her catheter is not blocked, and would need to receive a careful, thorough explanation of how to go about this.

  - *Limited involvement of health workers.* Because modern health personnel may have had limited opportunities to explore the sociocultural context of childbirth and care, providers may have difficulty showing empathy for fistula clients.
- **Lack of skilled providers:** Developing countries often have very few surgeons, nurses, and support staff trained in providing services for fistula repair.
- **Aversion to reproductive health services:** Because trust in the safety and quality of health care may be very low in poor areas, services are often not used.

Despite the obstacles, when quality surgical repair is made available, demand for services increases greatly. Many women will travel for days to reach a hospital that has a surgeon who can perform fistula repair. And when women hear of a provider visiting their region, hundreds turn up for a chance at a cure, creating a large backlog in the operating theater or the facility as a whole.

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Participant Handout 3-E

Prevention of Obstetric Fistula

While treatment of fistula is critical, prevention is even more important. Delaying and reducing adolescent pregnancies and making family planning available to all who want to use it would considerably reduce maternal disability and death. Complementing these advances with skilled attendance at all births and emergency obstetric care for women who develop complications during delivery would make fistula as rare in the developing world as it is in developed countries. Approaches for addressing the social issues that contribute to the problem—such as early pregnancy, girls' lack of education, poverty, and women's lack of empowerment—are critical interventions as well.

A Comprehensive Approach to Preventing Obstetric Fistula

An effective approach to addressing the problem of obstetric fistula must focus on both prevention and treatment, especially where access to good obstetric services is limited. The problem of fistula is likely to endure until maternal health services reach the poorest and most vulnerable members of society. Engaging the communities at risk in problem recognition, root-cause analysis, and problem solving contributes to effective partnerships for addressing fistula prevention and management. Before all women can receive adequate maternal care, a country's health infrastructure often must improve substantially.

Three elements form the core of a comprehensive approach to **preventing** obstetric fistula:

1. Delaying and/or spacing pregnancies

Reducing the number of adolescent pregnancies is one of the first steps toward decreasing the frequency of pregnancy complications, including fistula. Many fistulas occur in adolescent girls, whose bodies might not be fully developed for childbearing (Wall et al., 2001).

Helping women plan pregnancies is another important step toward reducing the incidence of fistula. Many women living in rural areas, where fistula is most common, have little access to family planning information and services.

Strengthening the capacity of health care systems would improve family planning services for the rural poor. Better access to a range of contraceptive methods would help more people choose and continue using a method of their choice.

Offering family life education for women also can help reduce the incidence of obstetric fistula. Expanding health education and family planning programs provides women with information and services that can help them delay childbearing or space births farther apart, which helps reduce complications of childbirth.

2. Improving access to obstetric care, including emergency care

Improving access to quality obstetric care, including skilled attendance during labor and delivery, helps women avoid fistula. Access can be improved by addressing the three delays: (1) delays in deciding to seek care; (2) delays in reaching a health care facility; and (3) delays in receiving sufficient care at the facility.

- **Delays in deciding to seek care.** During the antenatal period, women and their families should develop a plan for the birth that includes arrangements for transportation to a health care facility, and they should be prepared to deal with possible complications. A health care provider can help families make such plans. Families, midwives, and other rural health providers should learn to recognize the warning signs of maternal complications during delivery. Increased awareness of women's reproductive health among families and community members, including husbands, mothers-in-law, community elders, and religious leaders, can support efforts both to prevent and to treat fistula.
- **Delays in reaching a health care facility.** Health care systems can develop better referral processes to help avoid delays in reaching care. Better transportation and communication between rural areas and hospitals and other centers that offer emergency obstetric care are vital to a functioning referral process. Families and communities can improve obstetric emergency preparedness by setting aside funds for emergency transport and related needs.
- **Delays in receiving attention at the facility.** To help avoid delays at the facility, doctors, nurses, and other medical personnel need better training, equipment, and supplies, and facilities need policies in place to fund or subsidize emergency and/or indigent cases. Skilled birth attendants should monitor labor through the use of a *partograph* (or partogram), a simple chart for recording information about the progress of labor and for monitoring the condition of a woman and her baby. The World Health Organization recommends the use of a partograph with every labor. This decision-making tool is a key to the prevention and treatment of prolonged labor and its complications, but in many developing countries it is still not widely used.

Until all women are assisted at birth by a skilled birth attendant, government health infrastructures and traditional birth attendants (TBAs) must collaborate to fill the gap. Trained TBAs could contribute much to the prevention of obstetric fistula in rural areas. Their services are often more accessible, acceptable, and adaptable than modern health services, because most trained TBAs are women from the same community as their clients, with an understanding of the culture. Trained TBAs are also in a good position to educate their community against early marriages and pregnancy, to advise women to seek skilled attendance at birth, and to recognize and facilitate the transfer of women suffering from prolonged labor.

Policies should promote prompt and quality essential and emergency obstetric care. Too many women die, or suffer morbidity like fistula, when receiving care in modern health care facilities. Health care facilities should have clear methods for assessing the quality of care and should take steps to improve and ensure the quality of all of the services they provide.

3. Addressing social issues

Social issues play an important role in the prevention of obstetric fistula. Changes in traditions that encourage early marriage and childbearing would allow more young women to reach full physical maturity before they begin childbearing. Education for young women helps to raise their economic and social status and promotes maternal health.

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Session 4
Understanding the Client's Perspective

Refer to pages 60 through 64 of the traumatic fistula supplement for alternative Session 4 Overview—Session Objectives, Points to Remember, Training Methods, Materials, and Advance Preparation

Session Objectives

During this session, the participants will:

- List the common demographic and social characteristics of women with fistulas and the different situations or conditions that lead clients to need fistula repair
- Develop case studies for three or four clients who represent these demographic and social characteristics, situations, and emotional and physical conditions (The case studies will be used for role-plays throughout the remainder of the workshop.)
- Explain ways to understand a client's perspective
- Describe how to sensitively and respectfully work with fistula clients
- Explain how cultural attitudes about gender can affect the treatment that fistula clients receive in service-delivery settings, the preventive care they are able to access, and their perceptions of providers

POINTS TO REMEMBER

- ✓ Ensuring privacy and confidentiality can help a client to maintain her dignity.
- ✓ Awareness of gender is an important element of providing services for the obstetric fistula client. Gender roles and expectations are often identified as factors hindering the rights and status of women, with adverse consequences that may affect family life, education, socioeconomic status, and health.
- ✓ Client-centered counseling and the facilitation of informed choices about reproductive health care, including when and how to be sexually active, depend on providers' awareness of issues related to sexuality.
- ✓ Women's ability to improve their reproductive health and achieve their reproductive intentions is deeply affected by the degree to which they are knowledgeable about and in control of their sexuality and sexual relationships.

Training Methods

- Brainstorm
- Large-group work
- Demonstration
- Small-group work
- Discussion
- Demonstration role play
- Presentation

Materials

- Flipchart paper, easel, markers, and tape
- Any materials (such as a sofa, blanket, curtain, or drape) that could be used to depict a clinic setting
- Participant Handout 4-A: Ensuring Clients' Confidentiality, Privacy, and Dignity
- Participant Handout 4-B: Sexuality

Advance Preparation

1. Prepare a flipchart listing the objectives of this session.
2. If you plan to use Option 2 in Part A of this session, select three or four case studies from Appendix E: Sample Case Studies to reflect a wide range of characteristics and situations of fistula clients, and prepare handouts of the selected case studies for all participants.
3. Review all handouts and make one copy for each participant.
4. Gather materials to depict a service-delivery setting.
5. Prepare two flipcharts, one entitled "Demographic and Social Characteristics" and one entitled "Social Situations and Emotional and Physical Conditions."
6. Prepare the flipchart (for Part B, Activity 2) on page 91 (top).
7. Prepare one flipchart table for each case-study client (either those that will be developed by the participants during Part A or those selected from the client case studies in Appendix E). Each table should be entitled "Addressing the Client's Feelings" and should have three columns: "Client's Feelings," "Why?" and "Provider's Response" (see sample on page 91, and see Trainer's Resource 4-A for a sample completed flipchart).

Situations That Might Threaten a Client's Confidentiality, Privacy, and Dignity

- Leaving a client lying in a busy, open area
- Situating a client with her feet facing toward an open, visible area, and with her genitals exposed
- Not using screens or curtains around a client
- Not adequately draping a client
- Openly discussing the client's case with anyone who walks by
- Allowing people to walk in and out of the area where a client is being examined or counseled
- Having casual conversations with other staff during a client's treatment and/or counseling
- Attempting to discuss discharge information or provide counseling in a busy, nonprivate environment

Addressing the Client's Feelings

Client's name: _____

Client's Feelings	Why?	Provider's Response

Session 4 Training Steps

Session Time (total): Option 1: 3 hours, 55 minutes; Option 2: 2 hours, 50 minutes

Refer to pages 65 through 74 of the traumatic fistula supplement (Supplement 4A and Supplement 4B), which cover two additional topics that should be addressed at the start of this session:

- *Overview of Mental Health, Stressors, and Protective Factors*
- *The Psychosocial Response to Sexual Violence and Traumatic Fistula*

These pages also include Supplemental Handouts 4-a and 4-b, to present and distribute to participants during these activities

PART A: DEVELOPING CASE STUDIES OF OBSTETRIC FISTULA CLIENTS

NOTE TO TRAINERS

Part A of this session offers two approaches to case study development. It is preferable to use Option 1 if time permits, as this is a key exercise for helping the participants develop empathy toward and an understanding of the varied needs and feelings of clients. If time is limited, however, Option 2 may be used to shorten the session (see page 107).

Option 1: Original Case Studies

Time: 1 hour, 30 minutes

Activity 1: Brainstorm *(20 minutes)*

1. Display the flipchart entitled "Demographic and Social Characteristics." Ask the participants to think about their clients who have obstetric fistula and to list their demographic and social characteristics. Write the participants' responses on the flipchart. (Guide the brainstorming session by referring to the sample categories listed in the Training Tip below.)
2. Display the flipchart entitled "Social Situations and Emotional and Physical Conditions." Ask the participants to think about their clients who have obstetric fistula and to list the social situations they may find themselves in (e.g., abandoned, living with their husband, and so on) and the emotional or physical conditions they might have when they arrive at the facility.

TRAINING TIP

Explain the difference between demographic and social characteristics, situations, and emotional and physical conditions, using the following examples:

- **Demographic and social characteristics:** age, marital status, parity, income, educational level, and social background
- **Social situations:** recent vs. long-term condition, stillborn vs. live-born baby, abandoned by partner vs. still living with partner, begging vs. cared for by family, having no living children vs. having living children
- **Emotional and physical conditions:** depressed vs. hopeful, complicated vs. uncomplicated fistula, suffered nerve damage to the legs vs. no nerve damage, fistula can be treated with surgery vs. fistula cannot be treated with surgery, afraid/nervous vs. not afraid/nervous, malnourished vs. well nourished, desiring future pregnancies vs. not desiring future pregnancies

Refer to pages 75 and 76 of the traumatic fistula supplement for additional training considerations for developing case studies related to traumatic fistula survivors.

Activity 2: Large-Group Work *(20 minutes)*

1. Tell the participants that they will develop client profiles as a large group (based on the list of demographic and social characteristics) and then work in small groups to develop a case study for each profile (based on the lists of situations and emotional and physical conditions).
2. Explain that the profiles should reflect the range of demographic and social characteristics seen among fistula clients. Each case-study client will be given a name, because the clients will be used in role-play exercises throughout the rest of the workshop. In the role plays, the case-study clients will be treated as if they are real fistula clients.
3. Start developing a client profile by asking the participants to suggest and agree on a woman's first name.
4. Write the woman's name at the top of a flipchart; then ask the participants to agree on the following characteristics of their client (see sample profiles in the Training Tip below):
    - Age
    - Number of children
    - Marital and socioeconomic status
    - Educational level
    - Any other demographic and social characteristics that seem relevant
5. When the group is satisfied with their client profile, repeat the process until you have completed three or four profiles.

NOTE TO TRAINERS

Develop three or four client profiles, depending on the number of participants. (Develop at least three, to reflect a range of demographic and social characteristics and situations of fistula clients. More than four profiles will take too much time to process during the role-play sessions.) **Do not divide the participants** into small groups until after all of the client profiles are complete; otherwise, they might develop duplicate sets of demographic and social characteristics.

Throughout the workshop, have the participants work in small groups, performing counseling role plays with each "client." Three or four participants per group would be best. Thus, the following numbers can be used as a guide:

- For six to 12 participants, develop three client profiles, with two to four participants per role-play group.
- For 12 to 20 participants, use four client profiles, with three to five participants per role-play group.

As noted in the introduction, this training will be more difficult to conduct if there are fewer than six or more than 15 participants.

When developing the profiles, focus only on the client's demographic and social characteristics. Do not discuss her physical situation or condition. That is what the small groups will do when they develop their case studies.

Sample Profiles:

- Tigest: age 12; first and only child was stillborn; nonliterate and has never been to school; married, but husband does not let her stay in the house; has no income and depends on husband for livelihood
- Mariam: age 18; first and only child was stillborn; nonliterate and has never been to school; husband threw her out of the house and has taken a second wife; parents cannot afford to have her in the house, so she is begging for food
- Maimouna: age 26; gave birth six times and experienced complications and fistula during birth of sixth child; has three living children; is second wife to husband; husband is distressed by her physical problems but is anxious to assist wife

Activity 3: Demonstration *(15 minutes)*

1. Tell the participants that they will work in small groups to develop case studies for each client profile.
2. First, demonstrate how to do this with one of the client profiles. Refer to the lists of situations and emotional and physical conditions, and ask the participants which of these would most likely apply to this particular client.

3. Write their responses on the flipchart with the client's name and demographic and social characteristics on it. Then ask the participants to tell a story about this client, including her relationship with her partner(s), the details about why she suffered an obstetric fistula, and what kind of fistula she has.

4. Write the participants' suggestions on the same flipchart. Finally, arrange all of the information listed on this flipchart in a logical order, and write the client's case study on a new flipchart. (See below for a sample case study.)

TRAINING TIP

Developing a case study is like writing a little story. First, you think about what you know about the main character (the client profile). Then you try to imagine what happened to the woman that resulted in her being in these situations and having these emotional and physical conditions. This information can be taken directly from the brainstorm lists of demographic and social characteristics and situations and emotional and physical conditions. The following is an example, but your demonstration sample should come from the participants' brainstorm lists.

Sample Case Study for "Aberesh"
Aberesh, Age 22, Ethiopia

At the age of 18, Aberesh was married to an older man in a remote rural area. She became pregnant immediately. The pregnancy was difficult. Labor was obstructed, and Aberesh was unable to deliver. On the third day, her relatives decided to get help. They sold a goat and paid men to carry Aberesh on a stretcher for six hours to the nearest hospital. When she arrived, it was too late to save the baby; her son was stillborn.

Aberesh was so weak and exhausted from the ordeal that she could not get out of bed. It took another four weeks before she could walk by herself again. Two days after giving birth, she began to leak urine from a fistula. Nothing would stop the flow.

—Adapted from a personal story provided by the Addis Ababa Fistula Hospital

Activity 4: Small-Group Work *(25 minutes)*

1. Divide the participants into small groups (one group for each of the remaining client profiles), and assign one profile to each group.

2. Ask the participants to refer to the list of situations and emotional and physical conditions and to identify those that apply to their client.

3. Allow the groups 20 minutes to write their cases, putting their final draft on a flipchart.

TRAINING TIP

Circulate frequently among the groups. First, check with each group to see if they understand the assignment. Then keep checking on the groups to make sure that they are making the situations and emotional and physical conditions realistic, and that they are not telling the same story about two different clients. You might have to negotiate with the groups to convince them to adjust their stories slightly, so that the case studies reflect the variety of situations and emotional and physical conditions listed by the participants in the previous activities.

Activity 5: Discussion *(10 minutes)*

1. Ask for a volunteer from each group to present the group's case study.
2. Allow a few questions to clarify or suggest changes, but do not encourage major revision.

TRAINING TIP

When each group presents its case study, the participants in the other groups are likely to have different opinions about how each case study is written. As the possibilities for the case studies are endless, it is not necessary to have all of the participants agree on every aspect of each one. That is why the discussion of each case study should be limited. However, if one group has clearly presented a case study that is not realistic for the local situation, work with that group separately to revise it, instead of trying to revise it in front of the rest of the participants. After the case studies have been presented, post the flipcharts on the wall in a place where they will remain visible and uncovered.

Option 2: Adapted Case Studies

NOTE TO TRAINERS

If time is extremely limited and you elect to use Option 2, select three or four of the sample case studies found in Appendix E. (This should be done before the session.) The case studies you select should reflect a wide range of client characteristics and situations, including age, parity, marital status, economic status, complicated vs. uncomplicated fistula, and so on.

Time: 25 minutes

Activity 1: Presentation and Small-Group Work *(15 minutes)*

1. Present the three to four case studies you selected from Appendix E. Distribute the handout that you prepared before the session.
2. Divide the participants into small groups (one for each of the case studies) and assign one case study to each group. Explain that the stories are varied and that they are meant to reflect the range of demographic and social characteristics, situations, and emotional and physical conditions among women with fistulas.
3. Give each group 10 minutes to adapt their case study to fit the local situation.
4. Tell each group to write a final draft of the case study on a flipchart.
5. Remind the participants that each case-study client has a name because the clients will be used in role-play exercises throughout the rest of the workshop. In the role plays, the sample case-study clients will be treated as if they are real fistula clients.

Activity 2: Discussion *(10 minutes)*

1. Ask for a volunteer from each group to present the group's case study.
2. Allow a few questions to clarify or suggest changes, but do not encourage major revision. (See the Training Tip in Activity 5 of Option 1.)

PART B: CONFIDENTIALITY, PRIVACY, AND DIGNITY

Time: 25 minutes

Activity 1: Brainstorm *(10 minutes)*

1. Ask the participants what the words confidentiality, privacy, and dignity mean.
2. Briefly note their responses on a piece of flipchart paper.

Activity 2: Large-Group Exercise *(15 minutes)*

1. Reveal the prepared flipchart and ask the participants to review the list of situations that might threaten a client's confidentiality, privacy, and dignity. *(5 minutes)*
2. Pass out paper to the participants, and instruct them to write down what they would do to ensure privacy and prevent the situations described on the flipchart.

3. Invite volunteers to share their responses.
4. Using Participant Handout 4-A, discuss with the participants some of the options that exist for safeguarding client's confidentiality, privacy, and dignity.
5. Ask the participants how they can apply what they learned in this discussion at their own service sites. Focus the discussion on ensuring confidentiality, privacy, and dignity within the participants' service-delivery settings, rather than in an ideal situation.

Refer to page 77 of the traumatic fistula supplement for information about a DVD addressing clinical counseling for survivors of sexual violence.

PART C: ADDRESSING THE CLIENT'S FEELINGS

Time: 1 hour, 35 minutes

Activity 1: Brainstorm *(20 minutes)*

1. Explain that clients have other needs and concerns besides confidentiality, privacy, and dignity, including emotional, informational, and economic needs. Explain that the group will focus on informational needs later in the workshop and that economic needs can be addressed by referring clients to local resources that might lie outside the health care system. (This also will be discussed later in the workshop.) This exercise will help the participants focus on the emotional needs and concerns of clients during all phases of treatment.
2. Ask the participants to think about the case-study clients they developed (or discussed) earlier and what feelings those clients might have, from the time they arrive at the site until the time they leave.
3. Using the prepared flipchart table, "Addressing the Client's Feelings," list the feelings for each case-study client. Leave plenty of space between each feeling listed in the "Client's Feelings" column to match up with the longer writing expected in the "Why?" and "Provider's Response" columns.

   Note: Remind the participants that no matter what is in the "Why?" column, the provider should:

   - Listen actively/effectively to find out what the client feels and why, and so that he or she can provide specific contextual information and reassurance related to that fear/feeling
   - Be aware of his or her own possible negative bias toward the client, and try not to be judgmental
   - Always treat the client with respect, regardless of her socioeconomic situation, her fears, and any other issues
4. When the participants have completed the feelings list for each case-study client, ask them why the client might have each of the feelings identified. Briefly record their responses on the flipchart. Leave the third column blank until the small-group work.

TRAINING TIP

Remind the participants to focus on feelings specific to obstetric fistula clients, and help them clarify the reasons why clients have these feelings (particularly if it seems that the participants have not fully understood the exercise).

Clients might feel afraid, dirty, guilty, ashamed, or anxious. They might also feel that they are a social disgrace to their families and so deserve to be outcasts.

In all settings and cultures, women who have had a stillbirth experience a great sense of loss and disappointment; women might experience shame and guilt about giving birth to a stillborn child.

Activity 2: Small-Group Work *(30 minutes)*

1. Divide the participants into the same small groups they were in when they developed or discussed the case-study clients. Give the flipchart for each case-study client used above to the group that developed or discussed it.
2. Ask each group to fill in the third column for their respective case-study clients. They should ask themselves: What can the provider do when a client is feeling this way?
3. Ask each group to choose a spokesperson who will report to the rest of the participants during the large-group discussion.

Activity 3: Discussion *(45 minutes)*

1. Post the "Addressing the Client's Feelings" flipcharts on the wall, alongside the respective case-study flipcharts.
2. Ask the spokesperson from each group to share the group's ideas. Ask for comments or questions from the rest of the participants.

PART D: SEXUALITY ISSUES

Time: 25 minutes

Activity 1: Brainstorm/Large-Group Discussion *(10 minutes)*

1. Ask the participants to brainstorm a definition of *sexuality*, and write it on a piece of flipchart paper. Discuss this definition and clarify any misconceptions.

2. Present the following definition of sexuality and briefly explain why it is important to discuss its role in providing services for women who have an obstetric fistula:

> *Human sexuality encompasses the sexual knowledge, beliefs, attitudes, values, and behaviors of individuals. It deals with the anatomy, physiology, and biochemistry of the sexual response system; roles, identity, and personality; and individual thoughts, feelings, behaviors, and relationships.*
>
> —Definition developed by the Sexuality Information and Education Council of the United States (SIECUS)

TRAINING TIP

Sexuality, when defined as above, is an important aspect of obstetric fistula, family planning, and reproductive health care. Client-centered counseling and the facilitation of informed choices in reproductive health, including when and how to be sexually active, require providers to be aware of issues related to sexuality. A client's sexual history, relationships, and circumstances can play an important part in her ability to:

- Remain abstinent for the recommended period after surgery for obstetric fistula
- Choose to use a contraceptive method to delay pregnancy until her body has healed from surgery
- Make the decision to be screened and treated for sexually transmitted infections during admission for surgical repair of an obstetric fistula

In addition, women's ability to improve their reproductive health and achieve their reproductive goals is deeply affected by the degree to which they are knowledgeable about and in control of their sexuality and sexual relationships. Health care providers can empower women by supporting them in the process of developing knowledge and control.

Activity 2: Large-Group Discussion *(15 minutes)*

1. Facilitate a discussion about what the participants learned about sex and gender as children and how this influences their work as service providers.

2. Address some or all of the following questions during the discussion:
   - What messages does society give about when women are supposed to have sex for the first time and with whom (e.g., after menarche; after marriage regardless of menarche; with her husband)?
   - What messages does society give about when men are supposed to have sex for the first time and with whom (e.g., before marriage; with a prostitute)?
   - Do you think your fistula clients learned about sex in the same ways you did? What are the similarities? What are the differences?
   - Why is it important for us to consider how clients with fistula learned about sex and sexuality? How does it apply to our work when providing services for women with fistula?

- How do our own sexual experiences and learning about sexuality affect our ability to counsel clients with fistulas about issues related to sexuality and gender?
- How can you be sensitive to gender issues that your clients with fistula might face?
- How can you help fistula clients be more comfortable discussing sexuality issues with you?

3. Distribute Participant Handout 4-B to all of the participants.

TRAINING TIP

When discussing responses to the questions above, include the following points:

- Our own inhibitions and attitudes about sexuality might affect the way we talk to our clients about sex, as well as our comfort in doing so. Understanding where our own feelings and beliefs originate can help us empathize with the experiences of clients and with the difficulties we all have in talking about our sexuality.
- Sexual practices and relationships are affected by the way we feel about sex, what we think is proper and improper, and what it means to relate to another person in a sexual way. These types of thoughts and feelings are often filled with emotions—including, for example, pleasure, but also sometimes fear, guilt, shame, or embarrassment. These feelings come from our personal experiences as well as from the meanings that our society and culture attach to sex.
- This exercise alone might not help us feel more comfortable discussing sexuality with our clients, but it can be a helpful step in the process.
- We can use the case-study clients as examples throughout the discussion, to apply what we have learned to hypothetical obstetric fistula clients.

Exercise adapted from: EngenderHealth. 2002. *Integration of HIV/STI prevention, sexuality, and dual protection in family planning counseling: A training manual.* New York.

Session 4
Handouts and Resources

Participant Handout 4-A

Ensuring Clients' Confidentiality, Privacy, and Dignity

Confidentiality means not discussing the client's personal information with her partner, with the family member(s) accompanying her, or with staff members who are not directly involved in her treatment (except where required in a life-threatening emergency). Her personal information includes her medical history and the conditions prompting her to seek care, the services provided to her, and the family planning decisions she makes. (If she wants to involve a spouse or partner in decision making, however, her wishes should be followed.)

Privacy means having the power to control information about oneself; being protected from observation, intrusion, or attention by others; and being apart from other people and not seen, heard, or disturbed by them during care. It is critical to protect the client's confidentiality, sense of security and dignity, and willingness to communicate honestly. Often, simple changes in the physical setting where clients are treated or counseled will offer them more privacy.

Dignity means that a client can feel self-worth and honor, regardless of her physical circumstances. Ensuring privacy and confidentiality can help a client maintain her dignity.

The following situations might safeguard a client's confidentiality, privacy, and dignity:

- Keeping a client on a stretcher trolley, in a private quiet examination, or in a recovery room with curtains
- Properly draping a client to maintain her privacy and keep her warm
- Examining a client in a private examination room with a locked door during an examination, or, if there is no room, using screens around the client
- Keeping all information from a client confidential
- Ensuring auditory and visual privacy in the area where the client's treatment and/or counseling is taking place
- Providing information (discharge information or counseling) in a space that ensures visual and auditory privacy from other people, including staff

The following situations might threaten a client's confidentiality, privacy, and dignity:

- Leaving a client lying in a busy, open area
- Situating a client with her feet facing toward an open, visible area, and with her genitals exposed
- Not using screens or curtains around a client
- Not adequately draping a client
- Openly discussing the client's case with anyone who walks by
- Allowing people to walk in and out of the area where a client is being examined or counseled
- Having casual conversations with other staff during a client's treatment and/or counseling
- Attempting to discuss discharge information or provide counseling in a busy, nonprivate environment

Participant Handout 4-B

Sexuality

Human sexuality encompasses the sexual knowledge, beliefs, attitudes, values, and behaviors of individuals. It deals with the anatomy, physiology, and biochemistry of the sexual response system; roles, identity, and personality; and individual thoughts, feelings, behaviors, and relationships.

—-Sexuality Information and Education Council of the United States (SIECUS)

Sexuality, when defined as above, is an important aspect of obstetric fistula, family planning, and reproductive health care. Client-centered counseling and the facilitation of informed choices in reproductive health care, including when and how to be safely sexually active, require providers to be aware of issues related to sexuality. A client's sexual history, relationships, and circumstances can play an important part in her ability to:

- Remain abstinent for the recommended period after surgery for fistula
- Choose to use a contraceptive method to delay pregnancy until her body has healed from surgery or to help achieve a desired pregnancy when she is physically and emotionally ready
- Make the decision to be screened and treated for a sexually transmitted infection, including HIV.

In addition, women's ability to improve their reproductive health and achieve their reproductive goals is deeply affected by the degree to which they are knowledgeable about and in control of their sexuality and sexual relationships. Health care providers can empower women by supporting them in the process of developing knowledge and control.

Below are some examples of problems that an obstetric fistula client might face related to sexuality:

- Wanting to be sexually active but feeling worried that her partner will no longer desire her, even though the surgical repair of the fistula was successful
- Wanting to be sexually active but feeling unable to talk with her partner about a urostomy or colostomy that was performed when surgical repair was unsuccessful
- Understanding the need to abstain from penetrative vaginal intercourse for at least three months after surgical fistula repair, but lacking choice or control over when and how to engage in penetrative sexual activity, or lacking the ability or confidence to negotiate nonvaginal or nonpenetrative sexual options
- Wanting to delay pregnancy and protect herself from HIV and other sexually transmitted infections after surgical fistula repair, but having a partner who refuses to use a condom, being too uncomfortable to negotiate condom use herself, or being unaware of family planning options.

Some ways to respond to the client's concerns include the following:

- Assure the client that all conversations will be kept confidential.
- Address concerns in a respectful, nonjudgmental manner.
- Acknowledge that it might be difficult for the client to talk about sexual activity, but let her know that it might be helpful if she is to prevent damage to the surgical fistula repair and/or prevent a pregnancy until her body has healed and/or achieve a pregnancy when she is ready.
- Refer clients to counselors, psychologists, or other resources within or outside of the institution.

Trainers' Resource 4-A

Sample Completed Flipchart

Addressing the Client's Feelings {Note: DO NOT COPY CONTENT}

Client's name: Aberesh

Client's Feelings	Why?	Provider's Response
FEAR	**Fear of:**	**Examples:**
	• Surgery	• Explain what to expect before, during, and after surgery
	• Experiencing complications resulting from the surgery	• Explain the risk of complications compared with the disadvantage of not having the fistula repaired
	• Never being able to carry a pregnancy to term	• Listen • Reassure the client; explain what would determine whether or not the woman is likely to conceive and carry a pregnancy to term • Find out why or what the client fears
	• Becoming infertile	• Provide information on causes
	• Becoming disabled	• Arrange for referral for other services, if needed
	• Dying	• Reassure the client that though there is an operative risk, everything will be done to protect the client from dying.

Session 5
Interpersonal Communication

Refer to pages 80 through 85 of the traumatic fistula supplement for alternative Session 5 Overview—Session Objectives, Points to Remember, Training Methods, Materials, and Advance Preparation.

Session Objectives

During this session, the participants will:

- Explain the differences between one-way and two-way communication
- Discuss the benefits of two-way communication and of using open-ended questions for counseling
- Demonstrate the use of simple language and visual aids to explain the pathology and treatment of obstetric fistula
- Describe the REDI framework for counseling:
  - Rapport-building
  - Exploration
  - Decision making
  - Implementing the decision
- Identify the gaps in their practice, after comparison with the REDI counseling framework
- Discuss the importance of applying counseling frameworks to each client's unique situation
- Address the social context for decision making in counseling

POINTS TO REMEMBER

- ✓ *Two-way communication* may take more time, but it is more efficient in terms of ensuring that each person has been accurately understood.
- ✓ The steps in active and effective listening are CLEAR: Clarify, Listen, Encourage, Acknowledge, and Repeat.
- ✓ *Open-ended questions* are useful for exploring a client's opinions and feelings and are more effective than closed-ended questions for determining a client's needs (in terms of information or emotional support) and what she already knows.

(continued)

POINTS TO REMEMBER *(continued)*

- ✓ *Closed-ended questions* may be suitable for determining a client's condition and medical history at the beginning of medical treatment or counseling.
- ✓ A fistula client's emotional needs and concerns might change from one phase of treatment to another.
- ✓ Information provided to a fistula client should be anatomically correct and should be provided in language and a format that she can understand and at a time when she is emotionally ready to receive it.
- ✓ The elements of the REDI counseling framework are: Rapport-Building, Exploration, Decision Making, and Implementing the Decision.
- ✓ The client is more important than the counseling framework.

Training Methods

- Warm-up
- Large-group exercise/discussion
- Demonstration role play
- Brainstorm
- Presentation
- Small-group work

Materials

- Flipchart paper, easel, markers, and tape
- Erasable transparency markers or pencils (one per participant); use pencils if lamination and transparency markers are not available
- Overhead projector (optional)
- Two pieces of paper and one pencil for each participant
- A small piece of paper with an "emotion" word written on it (one for each participant)
- Participant Handout 5-A: One-Way and Two-Way Communication
- Participant Handout 5-B: Effective Listening
- Participant Handout 5-C: Closed-Ended and Open-Ended Questions
- Participant Handout 5-D: Female Reproductive Organs
- Participant Handout 5-E: Four Common Types of Obstetric Fistula
- Participant Handout 5-F: Prolonged Labor and Its Effect on the Reproductive Tract
- Participant Handout 5-G: REDI: Rapport Building, Exploration, Decision Making, and Implementing the Decision
- Transparency 5-A: Sample Diagram

Advance Preparation

1. Prepare a flipchart listing the objectives of this session.
2. Prepare transparencies of Participant Handouts 5-A and 5-B, and make one paper copy for use by a volunteer. If an overhead projector is not available, make one paper copy for each participant.
3. Review Participant Handouts 5-A through 5-G, and make one copy of each for each participant.
4. Prepare small pieces of paper (enough to give one to each participant) with one emotion written on each piece (e.g., sad, cynical, anxious, relieved, confused, angry).
5. Prepare several flipcharts like the example shown below for Part D, Activity 1:

Closed-Ended/Information Questions vs. Open-Ended/Feeling Questions

Questions	Structure (Closed- or Open-Ended)	Content (Information or Feeling)

6. Prepare a flipchart for each of the steps of the REDI Counseling Framework for Part F, Activity 2.

Rapport Building	**Already Doing**	**Need Training**	**Challenges Anticipated**
1. Welcome client.			
2. Make introductions.			
3. Introduce the subject of obstetric fistula.			
4. Assure client of confidentiality.			

Exploration	**Already Doing**	**Need Training**	**Challenges Anticipated**
1. Explore client's needs, risks, sexual life, social context, and circumstances.			
2. Assess client's knowledge and give information as needed.			

Decision Making	**Already Doing**	**Need Training**	**Challenges Anticipated**
1. Identify what decisions client needs to make.			
2. Identify client's options for each decision.			
3. Help client weigh the benefits, disadvantages, and consequences of each.			
4. Assist client in making her own realistic decision.			

Implementing the Decision	**Already Doing**	**Need Training**	**Challenges Anticipated**
1. Help client make a concrete, specific plan for carrying out the decision.			
2. Identify skills that the client will need to carry out the decision.			
3. Practice skills with client, as needed.			
4. Make a plan for follow-up.			

7. Use Handouts 5-D: Female Reproductive Organs, 5-E: Four Common Types of Obstetric Fistula, and 5-F: Prolonged Labor and Its Effect on the Reproductive Tract as transparencies. If an overhead projector is not available, prepare three flipcharts with the diagrams from Handouts 5-D, 5-E, and 5-F.
8. Review Handouts 5-D, 5-E, and 5-F, and make one laminated copy of each of the handouts for each participant. If lamination is not available, copy this handout on paper along with the others.
9. Gather the materials and prepare the room for practice role plays.

Session 5 Training Steps

Session Time (total): 4 hours, 35 minutes

PART A: TWO-WAY COMMUNICATION

Time: 30 minutes

Activity: Warm-Up *(30 minutes)*

1. Briefly brainstorm: What is one-way communication? What is two-way communication?
2. Ask for a volunteer to assist in this exercise.
3. Distribute paper and pencils to the participants. Explain that the volunteer is going to describe a drawing to them, and their task is simply to follow instructions in sketching what the volunteer describes. They cannot ask any questions or say anything.
4. Provide the volunteer with a copy of Transparency 5-A: Sample Diagram.
5. Ask the volunteer to describe what he or she sees on the sample diagram so the others can sketch it on one of their pieces of paper. The volunteer should not make eye contact with any of the participants and must use only verbal communication (no gestures or hand signals). Only one-way communication is allowed (no questions from the group).
6. After the volunteer has finished describing the diagram and before the next step of the exercise, ask the volunteer how she or he feels about the exercise. Ask him or her to check the participants' drawings to see how close they came to the sample diagram. (Do not show the sample diagram to the participants.)
7. Ask the other participants how they felt about the exercise. Write their comments on the prepared flipchart labeled "One-Way Communication."
8. Repeat this activity with a different volunteer and the same sample diagram. This time, however, allow the volunteer to make eye contact with the group and to have full and free two-way communication (i.e., participants can ask questions). Repeat the discussion questions as before.
9. When the exercise is over, project the diagram on the overhead projector (or distribute copies).
10. Summarize this activity by asking the following questions:
    - In the first attempt, how many of you got confused and just stopped listening? Why?
    - Why was the one-way communication so difficult to follow?
    - Why is two-way communication more effective than one-way communication?
    - Even two-way verbal communication cannot ensure complete understanding. How can we make our communication efforts more effective?
    - How does this exercise apply to our communications with fistula clients?
11. Distribute and summarize Participant Handout 5-A.

TRAINING TIP

In the discussion of one-way vs. two-way communication, the trainers should be sure to communicate to the participants that counseling generally requires two-way communication, with the provider and client interacting by providing information to each other, as well as feedback. For example, when explaining the medical treatment options for traumatic fistula, the provider (in this case, the sender) gives information to the client (in this case, the receiver), but he or she should also confirm that the client has understood and should ask if she has any questions (i.e., the provider should ask for feedback or a response from the client). This is one method for establishing two-way communication.

PART B: VERBAL AND NONVERBAL COMMUNICATION

Time: 30 minutes

Activity: Large-Group Discussion and Exercise *(30 minutes)*

1. Ask the participants to brainstorm a definition of verbal communication.
2. Explain that when they interact with clients, they should choose their words carefully, be sensitive to clients' feelings, and provide nonjudgmental care.
3. Ask the participants to give examples of words or statements that can be hurtful to clients and that can create a communication barrier.

TRAINING TIP

Examples of hurtful statements:

- "Don't sit on the chair. I don't want it to be soiled."
- To a crying client: "We are always telling you women to give birth in the health center or the hospital, but you insist on going to the TBAs; and you see now what happens."
- To another provider: "Bring that air freshener. This patient is making the room smell bad."

4. Ask the participants to brainstorm a definition of *nonverbal communication*. Ask them to list examples of how they can communicate with clients nonverbally.

TRAINING TIP

Examples of nonverbal communication:

- Nodding
- Holding the client's hand
- Maintaining eye contact*
- Giving looks of reassurance

Factors affecting nonverbal communication:

- Eye contact*
- Body language
- Tone of voice
- Facial expression

*Cultural norms regarding eye contact vary; in some cultures, maintaining eye contact is inappropriate.

5. Explain that nonverbal communication can sometimes send a stronger message to clients than verbal communication because it reveals our feelings and judgments.
6. Give an example of a simple phrase, such as "Good morning," and show how it can convey two completely different emotions depending on the nonverbal communication (e.g., tone of voice or facial expression) that accompanies it.
7. Give each participant a small piece of paper with an emotion written on it.
8. Going around the room, ask each participant to repeat aloud the phrase you used above (e.g., "Good morning"), using nonverbal communication to convey the emotion on their piece of paper.

Refer to pages 86 through 88 of the traumatic fistula supplement for additional points and a Supplemental Handout (5-a) to discuss at this point in this activity.

9. Summarize this activity by emphasizing the importance of recognizing the verbal and nonverbal signals that we send to clients. Remind the participants of the impact that these signals can have on their interactions with clients (and, therefore, on the quality of care that their clients receive).

PART C: ACTIVE/EFFECTIVE LISTENING

Time: 35 minutes

Activity 1: Large-Group Exercise/Discussion *(20 minutes)*

1. Ask the participants to count off by twos.
2. Ask all of the "ones" to leave the room. The second trainer should go with them and do the following:
   - Provide the group with a topic to discuss that should generate a lot of interest. (This can be a job-related matter, a news item of local interest, or a personal topic.)
   - Tell the group that when they return to the room, they will be asked to talk about this topic with a partner from the other group (the "twos") for approximately four minutes. Ask them to think about what they would like to say to their partner about this topic.

3. While the "ones" are out of the room, give the following instructions to the "twos":
   - This exercise is about listening.
   - When the other group comes back in the room, they will start talking to their respective partners in this group (you).
   - At first, you must act like you are not listening.
   - I will clap my hands after two minutes to signal that you can start listening.
4. Quickly brainstorm some ways in which the participants can show that they are not listening (e.g., by not making eye contact [depending on cultural norms], by playing with a pen, or by looking at their watches).
5. Invite the "ones" to return to the room.
6. Ask all of the "ones" to stand in a line, and ask the "twos" to stand in a line opposite from the "ones," so that everyone has a partner with the other number.
7. Ask each of the "ones" to start talking to the person opposite from them about the assigned topic.
8. After two minutes, clap your hands and allow the discussion to continue for another two minutes.
9. Facilitate discussion about this exercise by asking:
   - How did the talkers feel when their partners were ignoring them?
   - What were the signs that the partners were not listening?
   - How did it feel to the partners to act like they were not listening, and how did it feel when they began listening?
   - How does this exercise relate to your work?
10. Distribute Participant Handout 5-B.

Activity 2: Demonstration Role Play *(15 minutes)*

Model a few of the skills listed on Participant Handout 5-B, including empathy and reflection, in a short role play. Describe the skills displayed in the role play, and briefly summarize Participant Handout 5-B.

TRAINING TIP

Explanation of terms in Participant Handout 5-B:

- **Empathy** is achieved by putting oneself in the client's position and understanding her point of view as if it were your own.
- **Interpreting** involves ascribing a particular meaning or significance to how the client is responding verbally or nonverbally to information, her situation, and other issues you are discussing with her.
- **Reflecting** involves restating the client's thoughts and/or feelings in your own words. This technique allows the client to confirm and convey his/her understanding of how the client really feels.

Refer to page 89 of the traumatic fistula supplement for additional points to discuss at this point in Part C: Active/Effective Listening.

PART D: ASKING OPEN-ENDED QUESTIONS

Time: 45 minutes

Activity 1: Brainstorm *(20 minutes)*

1. Ask the participants to brainstorm questions that providers might ask one of the case-study clients from Session 4.
2. Write each question, in full and exactly as it is asked, in the "Questions" column on the flipchart entitled "Closed-Ended/Information Questions vs. Open-Ended/Feeling Questions." (Note: A sample completed flipchart is provided on the next page.)
3. Stop when you have 15 to 20 questions.

Refer to page 90 of the traumatic fistula supplement for an alternative list of sample questions to write on the flipchart used at this point in the activity.

Sample Completed Flipchart for Activity 1—DO NOT COPY CONTENT

Closed-Ended/Information Questions vs. Open-Ended/Feeling Questions

Questions	Structure (Closed- or Open-Ended)	Content (Information or Feeling)
1. How many children do you have?		
2. How did you feel when you found that you could no longer control your urine?		
3. What do you understand about labor that has gone on for too long?		
4. Did you go for antenatal care during your pregnancy?		
5. How were you caring for yourself during pregnancy?		
6. How would you feel about undergoing surgery to correct your leaking urine?		
7. What treatment options for leaking urine do you know about?		

Activity 2: Presentation *(10 minutes)*

1. Explain that questions can be considered in terms of two categories: their structure (closed-ended vs. open-ended) and their content (information vs. feeling).
2. Distribute and review Participant Handout 5-C.
3. Discuss the role of each type of question in counseling. Give one or two additional examples of questions for each category.

Activity 3: Large-Group Exercise/Discussion *(25 minutes)*

1. Return to the flipchart. For each question, ask the participants: Is this a "closed-ended" or an "open-ended" question? Is this an "information" or a "feeling" question?
2. Write "C" (for closed-ended) or "O" (for open-ended) in the first column; write "I" (for information) or "F" (for feeling) in the second column, as shown in the example on page 10.
3. Add up the total numbers of closed-ended, open-ended, information, and feeling questions.
4. Ask the participants how they would describe the questions most commonly used with clients, based on this exercise, and ask the participants to explain why they most commonly use certain questions.
5. Demonstrate how closed-ended questions can be made open-ended and how information questions can be changed to feeling questions, using two or three questions from the list.
6. Ask the participants to practice turning closed-ended questions into open-ended questions and information questions into feeling questions. For each closed-ended or information question on the brainstorm list, ask one participant to suggest how to ask it using an open-ended or feeling question. Go around the room until each participant has given a suggestion for changing at least one question.
7. Remind the participants that some closed-ended questions cannot and should not be converted into open-ended questions (see below).

TRAINING TIP

It is important to recall that some closed-ended and information questions are necessary in counseling, to assess the client's needs. The purpose of this activity is not to eliminate closed-ended and information questions, but rather to increase the use of open-ended and feeling-oriented questions, to allow the participants to better assess the client's informational and emotional needs and concerns.

8. Ask the participants how they can use this skill in their interactions with clients.

Refer to page 91 of the traumatic fistula supplement for an alternative sample of a completed flipchart.

Sample Completed Flipchart for Activity 3—DO NOT COPY CONTENT

Closed-Ended/Information Questions vs. Open-Ended/Feeling Questions

Questions	Structure (Closed- or Open-Ended)	Content (Information or Feeling)
1. How many children do you have?	C	I
2. How did you feel when you found that you could no longer control your urine?	O	F
3. What do you understand about labor that has gone on for too long?	O	I
4. Did you go for antenatal care during your pregnancy?	C	I
5. How were you caring for yourself during pregnancy?	O	I
6. How would you feel about undergoing surgery to correct your leaking urine?	O	F
7. What treatment options for leaking urine do you know about?	O	I

PART E: USING SIMPLE LANGUAGE AND VISUAL AIDS

Time: 1 hour, 25 minutes

Activity 1: Discussion *(20 minutes)*

1. Distribute Participant Handouts 5-D, 5-E, 5-F, and one transparency marker or pencil to each participant.

2. Using the prepared flipcharts or transparencies, review the pathology of fistula, identifying each body part shown. As you discuss the diagrams, ask the participants what terms are used locally to refer to each body part. Ask the participants how they can use the local terms when communicating with clients while also being aware of slang and unfavorable connotations.

Activity 2: Presentation *(20 minutes)*

1. Explain the importance and challenge of giving simple explanations to clients.
2. Ask the participants how they currently describe the pathology and treatment of obstetric fistula to women seeking care for fistula.
3. Write their responses on a new flipchart, and ask the participants to draw a sample diagram of the surgical treatment on a piece of paper. (This diagram can be used as a visual aid in Activity 3.)

Activity 3: Small-Group Skills Practice *(35 minutes)*

1. Explain that the purpose of this activity is to practice giving simple explanations and using visual aids.
2. Divide the participants into groups of three. Within each group, ask for one volunteer to play the role of the "provider" and another to act as the "client." The third person will be an observer. (The roles will shift for each role play, so that by the end of the exercise, each participant will have played the role of "provider.")
3. Give the following instructions: For each role play, the "provider" will have five minutes to explain some basic concepts and terms to the "client." *Remember to build on the client's current level of knowledge and to use the handouts as visual aids*. The client can ask questions at any time. After the role play is completed, the observer and the client will have five minutes to give feedback to the provider (within each small group), including what he or she did well and what could be improved.
4. Give the task for the first role play: Using handouts, visual aids, and simple language, explain to the client *why she has been leaking urine/stool, the cause of the obstetric fistula she suffers from, and the treatment options*.
5. Announce when the first five minutes have elapsed, and instruct the participants to end the role play and begin giving feedback. Announce when the second five minutes have elapsed, ending the feedback. *(10 minutes total)*
6. Ask the participants to shift roles (with each person, including the observer, taking on a new role). The new "provider" should build on the feedback given to the previous "provider."
7. Again, announce when five and 10 minutes have elapsed. *(10 minutes total)*
8. Ask the participants to shift roles (with each person, including the observer, taking on a new role). The new "provider" should build on feedback provided to the previous "provider."
9. Again, announce when five and 10 minutes have elapsed. *(10 minutes total)*

TRAINING TIP

During the role plays, remember to move from group to group to observe and make sure that the participants understand the instructions correctly. If one group is not following the instructions, correct them gently but immediately. If more than one group is confused, stop the role plays, explain the instructions again, and start over. If one participant in particular is having problems with the task, come back to that group for the feedback session and add your comments to the discussion.

If necessary, remind the participants to show visual aids to the client, rather than use them only for their own reference.

Activity 4: Discussion *(10 minutes)*

Ask the participants what they have learned from this session, both as "providers" and as "clients" in the role play, and how it can be applied in their work with fistula clients.

Refer to pages 92 through 96 of the traumatic fistula supplement, which cover an additional topic—Positive Reinforcement through Paraphrasing, Praise, Encouragement, and Empathy—that should be addressed at this point. It includes Supplemental Handout 5-b to present and distribute to participants during this topic.

PART F: COUNSELING FRAMEWORK: REDI

Time: 50 minutes

Activity 1: Warm-Up *(10 minutes)*

1. Divide the participants into four groups.
2. Introduce the exercise by telling the participants that they will now examine a framework for counseling the fistula client. Also let them know that there are other frameworks that they may have heard about for other aspects of reproductive health counseling (such as GATHER).

TRAINING TIP

Emphasize that the REDI steps can be used as a *guide* during counseling sessions. In all counseling, the client is more important than the framework. During the exercises and discussions that follow, the participants should keep in mind that frameworks can help providers by giving them a structure for their discussions with clients, so they do not miss important steps. However, a counseling framework is only useful if it allows providers to attend to the individual client's unique needs and concerns.

(continued)

TRAINING TIP *(continued)*

If participants are interested in learning more about other frameworks, the trainers can look into the GATHER (Greet, Ask, Tell, Help, Explain, Return) framework, which is commonly used for family planning counseling. REDI was chosen as the framework for fistula counseling because of its flexibility. More information can be found on both frameworks in EngenderHealth's *Comprehensive Counseling for Reproductive Health: An Integrated Curriculum*.

3. Distribute Participant Handout 5-G. Briefly review the phases and steps of the REDI Counseling Framework. Note that the REDI framework is designed to:
   - Emphasize the client's responsibility for making a decision and for carrying it out
   - Provide guidelines for considering the client's relationships and social context
   - Address the challenges that a client may face in carrying out this decision, and offer skills development to help the client meet these challenges

Refer to page 97 of the traumatic fistula supplement for additional point to discuss at this point during the activity.

Activity 2: Small-Group Work *(15 minutes)*

1. Post the prepared flipcharts about each phase of REDI. Write the following questions on a separate piece of flipchart paper. Explain that each group will consider one phase of REDI and answer the following questions for each step:
   - Which steps are you already doing in your work?
   - Which steps would require further training, whether to improve knowledge and skills or to make you more comfortable? *(Note to trainer: Further training might also be considered useful for steps that they are already doing.)*
   - Which steps would be difficult to implement, and why?
2. Assign one phase of REDI to each group, and distribute the corresponding flipcharts.
3. Explain to the participants that for each step, they should review the description in the handbook, consider the questions you wrote on the flipchart, and check any boxes in the table that apply to their work setting. They might check more than one box—or all three boxes—for some steps. If there are different opinions within the group, participants should put a question mark in the box.
4. Ask each group to choose one member to fill in the table for their group and another to serve as the group's "reporter," who will report back to the larger group about the small group's discussion.
5. Give the groups 10 minutes to complete their tables. Check with each group briefly to ensure that they understand the instructions. If some groups finish earlier than others, they can go on to other phases of REDI and discuss their answers to the three questions among themselves.

Activity 3: Discussion *(25 minutes)*

1. Starting with Rapport Building, ask the group reporter to post the group's flipchart and explain the group's findings. If there are question marks, ask for a brief explanation. Also ask for a brief explanation of the group's challenges. *(10 minutes total for all four groups)*

2. Ask the participants what they learned from this exercise. *(5 minutes)*

TRAINING TIP

Participants should note that they are probably already doing many of the counseling steps outlined in the REDI framework. The steps that they feel require additional training will be addressed in this workshop. Anticipated challenges might require training beyond the scope of this workshop. However, the trainers can share these anticipated challenges with participants' supervisors or program managers and this can be part of the training follow-up.

3. Facilitate a discussion by asking the following questions *(10 minutes)*:
   - How does this framework ensure that the counseling is client-centered?
   - How much time do providers in your facility generally spend counseling each client? Do you think this framework helps providers to work within this timeframe? Do you think providers can save time with this framework? If yes, how? If no, why not?
   - Why does the framework address the social context of clients' decisions?
   - Why does this framework ensure a client's informed and voluntary decision making?

REDI training adapted from: EngenderHealth. 2003. Principles and approaches for client-centered communication in sexual and reproductive health. In *Comprehensive counseling for reproductive health: An integrated curriculum*. New York.

Session 5
Handouts

Participant Handout 5-A

One-Way and Two-Way Communication

The drawbacks of **one-way communication:**

- Only one person is actively talking, giving no chance to the other person to ask questions or express feelings and opinions.
- In health care, the provider is not able to determine if the client has accurately understood the information given, which often leads to misunderstanding.
- One-way communication might take less time than two-way communication, but it is not efficient in terms of establishing understanding.

The benefits of **two-way communication:**

- Both persons are active in sharing information and opinions and in clarifying information with questions.
- This creates more discussion and interaction between the client and the provider, which enhances understanding by both parties and helps the provider determine whether the communication has met the client's needs.
- Although two-way communication takes more time than one-way communication, it is more efficient in terms of ensuring that each person has been accurately understood.

Participant Handout 5-B

Effective Listening

Listening skills can be improved through the following practices:

- Maintaining eye contact with the speaker (within cultural norms)
- Showing a genuine interest in the topic
- Being attentive to the speaker (i.e., not doing other tasks at the same time and not interrupting)
- Not talking to other people while listening
- Asking questions
- Showing empathy
- Reflecting (i.e., repeating, or using your own words to confirm understanding)
- Interpreting the feelings and emotions behind what is being said
- Integrating what has been said into further discussion

One easy way to remember the steps in active and effective listening is through the acronym CLEAR:

Clarify by asking questions about what the client said.

Listen and use nonverbal communication, such as nodding the head.

Encourage by asking questions.

Acknowledge the client by saying something like "That's okay."

Repeat by using your own words to confirm understanding.

Handout adapted from: Family Health International (FHI). 2003. Module 4: Communicating effectively as a peer educator. In *HIV & AIDS peer educators trainers' guide for IMPACT implementing agencies*. Arlington, VA.

Participant Handout 5-C

Closed-Ended and Open-Ended Questions

Closed-ended questions usually can be answered with a very short response, often just one word. A closed-ended question calls for a brief, exact reply, such as "yes," "no," or a number.

Examples include the following:

- How old are you?
- How many children do you have?
- Is your house far from this clinic?
- Did you go for antenatal care during your pregnancy?
- When did you start leaking urine?
- How long were you in labor before you gave birth?

These questions can be used to determine the client's condition and medical history at the beginning of medical treatment or counseling.

Open-ended questions are useful for exploring the opinions and feelings of the client; they usually require longer responses. Open-ended questions are more effective for determining the client's needs (in terms of information or emotional support) and what she already knows.

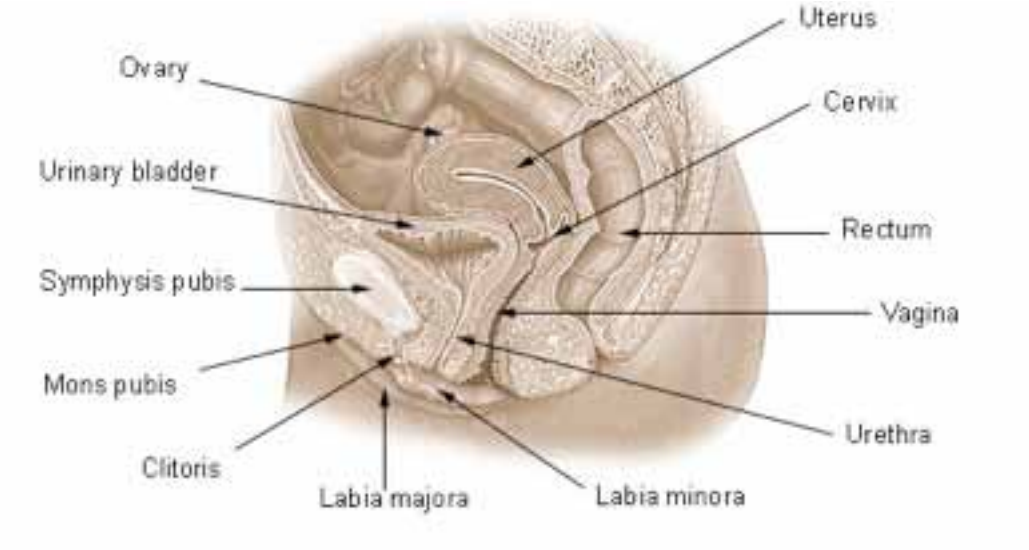
Examples include the following:

- How did you feel when you found that you could no longer control your urine?
- What do you understand about labor that has gone on for too long?
- How were you caring for yourself during pregnancy?
- How would you feel about undergoing surgery to correct your leaking urine?
- What treatment options for leaking urine do you know about?
- What do you think is going to happen while you are here? What concerns do you have about that?
- What questions or concerns does your husband or partner have about your condition?

Participant Handout 5-D

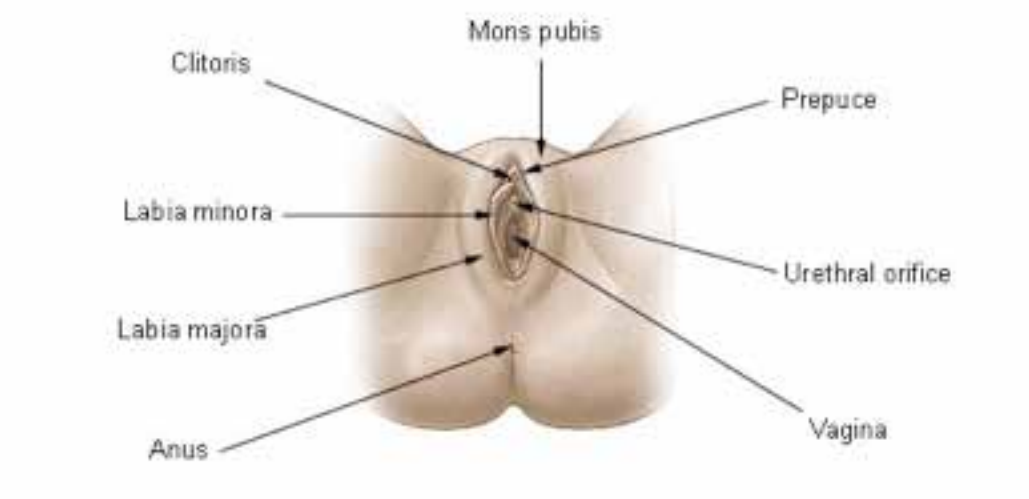
Female Reproductive Organs

Organs of the Female Reproductive System



Source: U.S. National Cancer Institute (NCI) Surveillance, Epidemiology and End Results (SEER) Program. [No date given.] Female reproductive system. Atlanta: NCI SEER Cancer Registry. Accessed at www.training.seer.cancer.gov/module_anatomy/ unit12_3_repdt_female.html/, March 12. 2008.

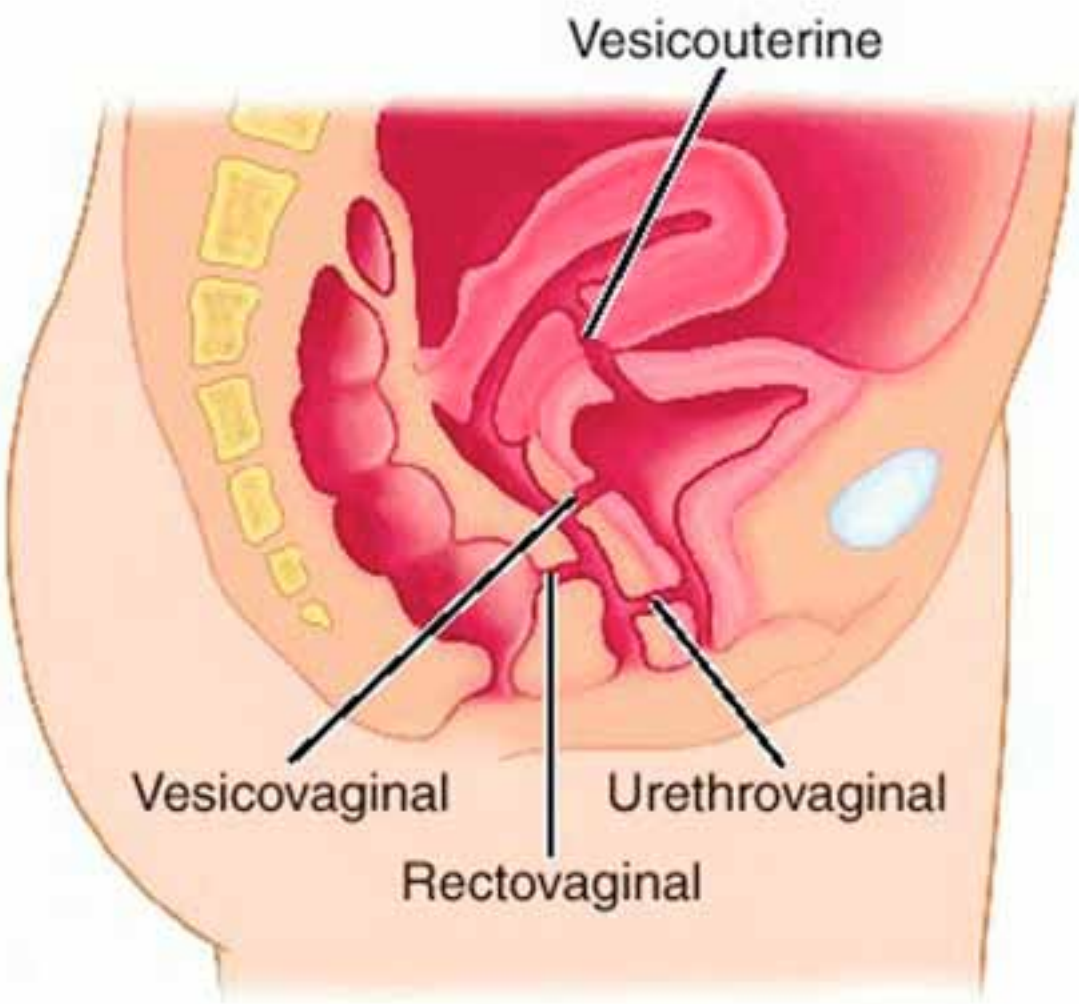
Female External Genitalia



Source: NCI SEER Program. [No date given.] External genitalia. Atlanta: NCI SEER Cancer Registry. Accessed at www.training.seer.cancer.gov/module_anatomy/unit12_3_ repdt_female3_genitalia.htmll/, March 12. 2008.

Participant Handout 5-E

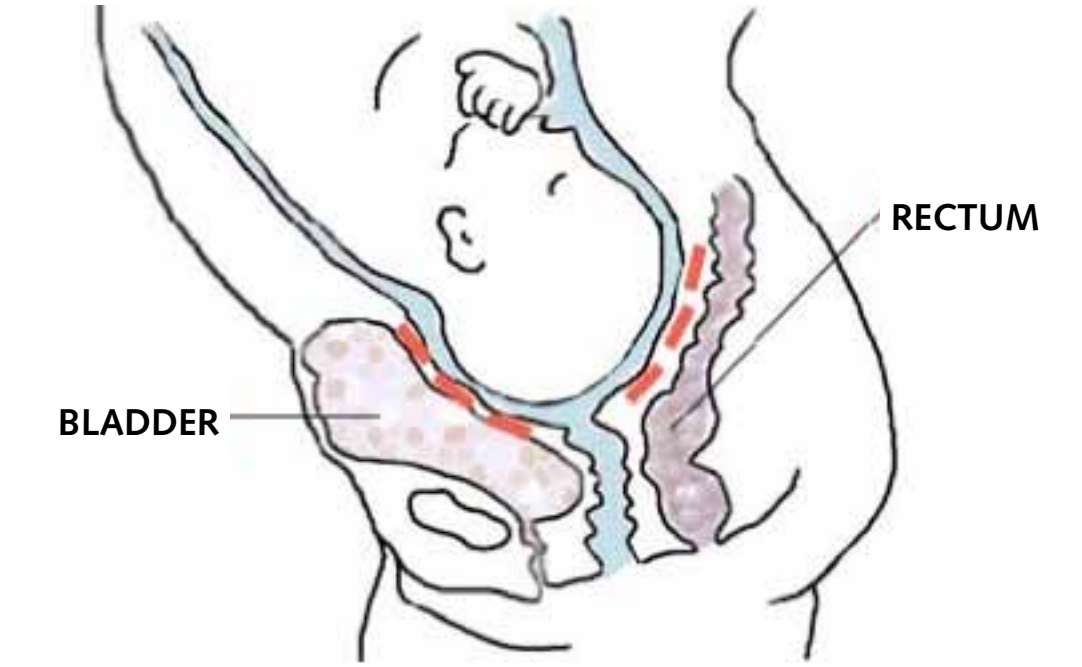
Four Common Types of Obstetric Fistula



Source: Merck & Co., Inc. 2006. *Dorland's illustrated medical dictionary*. Whitehouse Station, NJ.

Participant Handout 5-F

Prolonged Labor and Its Effect on the Reproductive Tract



Source: UNFPA. Campaign to end fistula. Retrieved from http://www.endfistula.org, Aug. 8, 2005.

Participant Handout 5-G

REDI: Rapport Building, Exploration, Decision Making, Implementing the Decision

Phase 1: Rapport Building

1. Welcome the client:
   - Greet the client warmly.
   - Help the client to feel comfortable and relaxed.
2. Make introductions:
   - Identify the reason for the client's visit.
   - Ask general questions, such as name, age, and number of children.
3. Introduce the subject of obstetric fistula:
   - Explain the need to ask certain questions.
   - Explain to the client the things that you will talk about.
4. Assure confidentiality:
   - Explain the purpose of and the policy on confidentiality.
   - Create an atmosphere of privacy by ensuring that no one can overhear your conversation, even if you are not able to use a separate room.

Phase 2: Exploration

1. Explore the client's needs, problems, and concerns:
   - Assess what the client understands about her problem (obstetric fistula and/or related issues), what worries or concerns she might have, and what she specifically hopes to accomplish through the visit.
   - Explore the client's pregnancy history and knowledge of and use of family planning methods and safe motherhood practices.
   - Explore other factors about the client's circumstances that may limit her power or control over decision making, such as financial dependence on a partner or family member, tensions within an extended family, and fear of violence, among others.

2. Assess the client's knowledge and give information, as needed:
    - Ask the client what she knows about how she got the fistula.
    - Ask what she knows about the fistula repair procedure, including the dangers and possible complications.
    - Correct misinformation and fill in any gaps in her knowledge.

Phase 3: Decision Making

1. Identify what decisions the client needs to make in this session:
    - Help the client to prioritize the decisions, to determine which are the most important to address today.
    - Explain the importance of the client's making her own decisions.
2. Identify the client's options for each decision:
    - Many clients (and some providers) feel that in most areas of sexual and reproductive health, the client's decision-making options are limited. An important role that the provider can play is to lay out the various decisions that a client can make and help her explore the consequences of each. This empowers the client to make her own choice, which is a key element of supporting the client's sexual and reproductive rights.
3. Weigh the benefits, disadvantages, and consequences of each option:
    - Make sure the discussion centers on options that meet the client's individual needs, taking into account her preferences and concerns.
    - Provide more detailed information, as necessary, on the options that the client is considering.
    - Consider who would be affected by each decision.
    - Explore with the client how she thinks that her partner or family members might react to the course of action (e.g., having the fistula repair surgery, having future pregnancies delivered in a health center, and so on).
4. Assist the client to make her own realistic decisions:
    - Ask the client what her decision is (i.e., what option she chooses).
    - Have the client explain in her own words why she is making this decision.
    - Check to see that this decision is her choice, free of pressure from her spouse, partner, family members, friends, or service providers.
    - Help the client to assess whether her decision can actually be carried out, given her relationships, family life, and economic situation.

Phase 4: Implementing the Decision

1. Assist the client in making a concrete, specific plan for carrying out the decision:
    - Be *specific*. If a client says that she is going to do something, find out when, under what circumstances, and what her next steps will be in each situation. Asking a client "What will you do next?" is important in developing a plan to reduce risk of damaging the surgical repair or developing another fistula. For example, if a client says that she will deliver her next baby at a health center or hospital, the provider should ask, "How will you get there?" "How will you pay for the visit?" "How will you tell your partner/family that you want deliver in a health center or hospital?"
    - Ask about possible consequences of the plan: "How will your partner/family react?" "Do you fear any disagreements?"
    - Ask about social supports: "Who can help you carry out the plan?" "Who might create obstacles?" "How will you deal with a lack of support or with individuals who interfere with the client's efforts to reduce risk?"
    - Help the client make a "Plan B." If the current plan does not work, what else can the client do?
2. Identify skills that the client will need to carry out the decision.
3. Practice skills with the client, as needed:
    - Partner communication and negotiation skills
        - Discuss the client's fears or concerns about communicating and negotiating with her partner or family members about maternal health concerns or family planning, and offer ideas for improving communication and negotiation.
        - Role-play with the client possible communication and negotiation situations.
    - Skills in using family planning methods
        - Make sure that the client (and/or her partner or family members) understands how to use the family planning method she selected; ask the client to repeat back basic information and encourage him or her to ask for clarification.
4. Make a plan for follow-up
    - Invite the client to return for a follow-up visit for ongoing support with decision making, negotiation, and behavior change.
    - Explain the timing for a medical follow-up visit or for contraceptive resupply.
    - Refer the client for services not provided at your facility.

Handout adapted from: EngenderHealth. 2003. Session 8: Counseling frameworks. In *Comprehensive counseling for reproductive health: An integrated curriculum*. New York.

Session 6
Counseling for the Fistula Client

Refer to pages 100 through 103 of the traumatic fistula supplement for alternative Session 6 Overview—Session Objectives, Points to Remember, Training Methods, Materials, and Advance Preparation.

Session Objectives

During this session, the participants will:

- *Describe:*
  - The purpose of counseling for fistula clients during each stage of service delivery
  - Information that should be provided to clients during each stage of service delivery
  - Concerns and needs of the client, before, during, and after the operation
  - The unique counseling needs of clients with special needs (i.e., clients who are very young, older, HIV-positive, physically disabled, or mentally/developmentally disabled)
- *Examine* counseling in the context of existing services for women with fistula
- *Demonstrate:*
  - How to create a comfortable environment for discussing clients' needs and concerns
  - Counseling during each stage of service delivery, using communication skills to address clients' needs through role plays.
  - Counseling women with special needs

POINTS TO REMEMBER

- ✓ Every individual who interacts with a client in a health facility has a role to play in helping the client feel more comfortable.
- ✓ There are six stages of service delivery:
  - First contact
  - Clinical intake
  - Preoperative management
  - Intraoperative management
  - Postoperative management
  - Discharge and follow-up

(continued)

POINTS TO REMEMBER *(continued)*

- ✓ The client's emotional and informational needs and the health facility staff responsible for providing care are different at each stage of service delivery.
- ✓ Counseling the fistula client:
  - Focuses on helping individuals to make choices and to manage the emotions associated with their situation
  - Goes beyond just giving facts, enabling clients to apply information to their particular circumstances and to make informed choices
  - Includes a discussion of feelings and concerns, because feelings and concerns are relevant to the client's choices, particularly regarding sexual behavior, reproductive health, and fertility
- ✓ A fistula client will need:
  - Up-to-date information and education about fistula and related care, which should be shared by providers using language the client will understand and using simple, clear messages
  - Emotional support
  - Quality clinical management
- ✓ The approach to clinical management will depend on the woman's physical condition when she arrives, the existence of any other diseases, the type of fistula, and the classification of the fistula.
- ✓ Women who may have special counseling needs include younger women, older women, women who are HIV-positive, women who are physically disabled, and women who are developmentally or mentally challenged.
- ✓ Postdischarge follow-up and care are important for successful reintegration and healing

Training Methods

- Presentation/discussion
- Brainstorm
- Role play

Materials

- Flipchart paper, easel, markers, and tape
- Flipcharts of the client case studies (from Session 4)
- Flipcharts entitled "Addressing the Client's Feelings" for each client (prepared for Session 4)
- Transparency 6-A: Sample "Map" for Case-Study Client Walk-Through of Services
- Handout 10-A: Sample Counseling Learning Guides
  Note: Use Session 10 handouts as transparencies.

- Participant Handout 6-A: Stages of Service Delivery
- Participant Handout 6-B: Counseling the Obstetric Fistula Client
- Participant Handout 6-C: Stages for Counseling the Obstetric Fistula Client
- Participant Handout 6-D: 10 Tips for Improving Counseling Services for Obstetric Fistula Clients
- Participant Handout 6-E: Overview of Clinical Intake
- Participant Handout 6-F: Overview of Admission and Preoperative Management
- Participant Handout 6-G: Overview of Surgical Intervention
- Participant Handout 6-H: Overview of Postoperative Management (first 14 days postoperative)
- Participant Handout 6-I: Overview of Discharge and Follow-Up
- Participant Handout 6-J: Discharge Information Sheet
- Participant Handout 6-K: Counseling Clients with Special Needs
- Props for role-plays, such as client-education materials, a blanket, a curtain, drapes, samples or pictures of fistula-related equipment or other materials that can be used to make the role plays more realistic
- Video camera and television or monitor (optional)

Advance Preparation

1. Prepare a flipchart listing the objectives of this session.
2. Review all handouts and make one copy of each for each participant.
3. Prepare six flipcharts with the following headings reflecting each stage of fistula care:
    - Intake
    - Admission
    - Preoperative
    - Intraoperative
    - Postoperative
    - Discharge
4. Prepare flipcharts with the following headings:
    - "Needs and Concerns—Initial Contact"
    - "Needs and Concerns—Clinical Intake"
    - "Needs and Concerns—Admission to the Ward and Preoperative Period"
    - "Needs and Concerns—Intraoperative Period"
    - "Needs and Concerns—Postoperative Period"
    - "Needs and Concerns—Successful Repair: Discharge and Follow-Up"
    - "Needs and Concerns—Unsuccessful Repair: Discharge and Follow-Up"

- "Assessing a Client's Readiness to Talk"
- "Creating a Comfortable Environment for Discussion"
- "Women with Special Needs"

5. Prepare the room so that each group can sit near its respective case-study and feelings flipcharts.
6. Gather the materials and prepare the room for practice role plays.
7. Set up the video camera and television or monitor (optional).

Session 6 Training Steps

Session Time (total): 5 hours, 35 minutes, to 6 hours

Refer to pages 104 through 120 of the traumatic fistula supplement (Supplement 6A and Supplement 6B), which cover two additional topics that should be addressed at the start of this session:

- *Dealing with the Challenges of Counseling Traumatic Fistula Clients*
- *Counseling Traumatic Fistula Clients (Psychosocial Issues)*

These pages also include Supplemental Handouts 6-a, 6-b and 6-c, to present and distribute to participants during these activities.

PART A: OVERVIEW OF COUNSELING

Time: 45 minutes

Activity 1: Large-Group Exercise/Discussion *(25 minutes)*

1. Ask for a volunteer to provide a "walk-through mapping" of services for fistula clients at his or her site, as follows: The volunteer should play the role of his or her case-study client and "walk through" the client's steps from the time she arrives at the facility until the time she leaves (or returns for follow-up). As the volunteer describes the steps, map them on a piece of flipchart paper.

TRAINING TIP

The sample walk-through and mapping of a case-study client should make the exercise interactive and should clarify what happens during each stage of service delivery at the participants' respective sites. The map should identify actual points of contact with different departments and service providers, and it can be used as a reference for how and when to counsel clients in the service-delivery process.

2. Distribute Participant Handout 6-A and compare this with what was written on the flipchart.
3. Briefly identify which services are lacking or need improvement. This will provide the participants with a tangible and familiar framework for considering and applying counseling services.

TRAINING TIP

Participant Handout 6-A clarifies the role of counseling in providing care for women living with obstetric fistula and reviews the elements of counseling, including who can provide counseling and the qualities and skills that are needed. Presenting this material at this point in the training serves three purposes: It gives a framework in which to fit the skills, attitudes, and knowledge addressed in Sessions 2 to 5, and it prepares the participants for the practice counseling they will do in the remainder of the training.

Activity 2: Discussion *(20 minutes)*

1. Ask the participants to describe the role of counseling in health services for women with fistulas. Clarify any misconceptions, answer questions raised by the participants, and distribute Participant Handout 6-B.
2. Explain to the participants that counseling skills and steps should always be integrated into their routine work with fistula clients. Remind them that all staff who interact with clients, even if only for a short time, share the responsibility for counseling.

Refer to pages 121 through 123 of the traumatic fistula supplement for additional discussion points and Supplemental Handout 6-d to distribute and discuss at this point in this activity.

3. Distribute Participant Handout 6-C and briefly summarize counseling needs during each stage of service delivery.
4. Distribute Participant Handout 6-D and briefly review the most important points.

PART B: COUNSELING FOR OBSTETRIC FISTULA CLIENTS

Time: 3 hours, 55 minutes, to 4 hours, 20 minutes

Activity 1: Brainstorm/Discussion *(45 minutes)*

1. Post the six labeled flipcharts on the walls.
2. Divide the participants into three groups and ask/assign each group to fill in the following on two of the flipcharts: (i) "needs and concerns" for the assigned stage of services delivery; and (ii) emotions that a client might feel during that time.
3. Reconvene the entire group and lead the members of each small group in a review of the content on each flipchart.

4. Close the exercise by asking the participants how the service provider can address these needs, both verbally and nonverbally. Then read the following quote to show how a provider can address a client's needs and feelings during the procedure:

> In some cultures, women may feel ashamed to sit for an extended period of time with their legs open, even though this is part of a clinical procedure. While providers cannot completely erase such feelings of shame, they can be sensitive to the client's concerns by means of simple gestures, such as draping her lower body whenever possible, holding her hand, telling her that many women feel a little uncomfortable in this situation, and reassuring her that this feeling is normal.
>
> —Margolis, A., Leonard, A. H., and Yordy, L. 1993. Pain control for treatment of incomplete abortion with MVA. *Advances in Abortion Care* 3(1):1–8.

5. Summarize the activity by explaining the importance of offering the client reassurance and attention.

Activity 2: Brainstorm/Discussion *(30 minutes)*

1. Ask the participants: How can you determine if it is a good time to talk with a client about her needs and concerns? Write their ideas on the prepared flipchart entitled "Assessing a Client's Readiness to Talk."

TRAINING TIP

The process of assessing a client's readiness to talk and of creating a comfortable environment will differ from place to place, depending on her condition, the local culture, and specific features of the service site (e.g., hospital versus clinic setting). The following examples may be used to help guide the discussion:

- Observe the client's appearance: Is she conscious, alert, oriented? Does she look sleepy, in pain, scared, or agitated?
- Ask: "How are you feeling?"
- Ask: "You may have some questions about what is going on. Is this a good time for us to talk?"

2. Post the completed flipchart on the wall for reference during the remainder of this session.
3. Ask the participants to list ways of creating a comfortable environment for openly discussing clients' needs and concerns.
4. Write their ideas on the prepared flipchart entitled "Creating a Comfortable Environment for Discussion."
5. Demonstrate how to arrange the setting and speak softly when sitting or standing close to the client, as described below.

TRAINING TIP

Some examples of ways to create a comfortable environment for discussion include:

- Arranging the setting so it is conducive to a confidential discussion with the client (e.g., by drawing a screen or curtain for visual privacy, or making sure you are far enough away from other clients and staff so you cannot be overheard if you speak softly)
- Sitting or standing on the same level as the client
- Assuring the client of confidentiality (i.e., that everything she says will remain between you and her, unless other medical staff who are treating her need to know)
- Acknowledging that feeling scared, confused, or worried are common emotions for most women in this situation
- Asking if there is anyone else that she would like to have involved in the discussion (e.g., her partner or family members)

6. Post the completed flipchart on the wall for reference during the remainder of the workshop.

TRAINING TIP

After the participants have developed flipchart lists specific to their own cultures and sites, you might want to have these typed, copied, and distributed as handouts before the end of the workshop.

Activity 3: Role-Play Preparation *(10 minutes)*

Note: During the role plays, the participants will use the case-study clients (from Session 3) as characters. This role-play technique will be used to conduct role plays for each stage of care. While the process is the same for each role play, the transparencies and handouts will differ.

1. To provide a guide for counseling, project a transparency of Participant Handout 10-A (the Sample Counseling Learning Guides).

2. Distribute handouts for each stage of care. Participants may use this as a reference to assist them in developing messages for the client in the case study. This is just a guide, and participants should compare this with protocols from their respective institutions.
   - Participant Handout 6-E: Overview of Clinical Intake

Refer to pages 124 through 134 of the traumatic fistula supplement for an alternative version of Participant Handout 6-E: Overview of Clinical Intake to distribute at this point in the activity.

- Participant Handout 6-F: Overview of Admission and Preoperative Management
- Participant Handout 6-G: Overview of Surgical Intervention
- Participant Handout 6-H: Overview of Postoperative Management (first 14 days postoperation)
- Participant Handout 6-I: Overview of Discharge and Follow-Up

Refer to pages 135 through 137 of the traumatic fistula supplement for an alternative version of Participant Handout 6-I: Overview of Discharge and Follow-Up to distribute at this point in the activity.

- Participant Handout 6-J: Discharge Information Sheet

3. Divide the participants into the five groups, using the same case-study client groups as on the first day of the workshop and seating each group near where its case-study and feelings flipcharts are posted on the wall. Assign each group a different stage of care (i.e., either "Clinical Intake," "Admission and Preoperative Management," "Surgical Intervention," "Postoperative Management," or "Discharge and Follow-Up").

4. Ask each group to:
   - Develop a five- to 10-minute role play for counseling during clinical intake. The counseling session should accomplish the following communication tasks:
     - Assessing the client's readiness to discuss her concerns and feelings
     - Encouraging the client to ask questions and express her opinions and feelings
     - Answering the client's questions with simple explanations
   - Remember to use the open-ended or feeling questions that the participants developed to address the sexuality and gender concerns.
   - Remember to show examples of *reflecting* (i.e., interpreting the feelings behind a client's words).

5. Distribute props to each group.

6. Encourage groups to use the standardized counseling checklists in their handbook for the relevant stage of service delivery..

7. Walk around the room and offer help as the participants develop their role plays.

TRAINING TIP

You may need to remind the participants of the following objectives of the role play:

- Take the role play seriously. (This is an opportunity to practice for interactions with real clients the next day.)
- Be realistic in the scenarios they present.

(continued)

TRAINING TIP *(continued)*

- Tailor the conversation to fit the individual client's needs, rather than using a discussion script with irrelevant information. (For example, if a client wants to be pregnant again soon, she is probably not interested in long-acting family planning methods.)
- Ask questions, rather than making assumptions, about what the client needs or wants.

Refer to page 138 of the traumatic fistula supplement for an additional Training Tip for this activity.

Activity 4: Role-Play Presentation *(20 to 25 for each of five stages)*

1. Have each group conduct their role play for other participants to observe.
2. Introduce the role play by reminding the participants of the circumstances of the case study.
3. Videotape the role play (optional).
4. Stop the role play if it exceeds the 10-minute time limit.
5. Play the videotape of the role play (if video is used) and lead a discussion (10 minutes) by asking the following questions:
   - How do you think the client felt during this role play?
   - Which communication tasks were achieved?
   - Was the information that was provided technically accurate?
   - Were technical issues explained through the use of simple language?
   - What did the group do well? Start by asking the group to evaluate themselves; then ask other participants for their feedback. Finish by providing a summary of positive feedback.
   - How could they improve (both the technique and the content)? Start by asking the group to evaluate themselves; then ask other participants for their feedback. Finish by providing a summary of ways the group could improve.
6. Summarize the feedback and add any points that were not covered by the participants.

TRAINING TIP

Some participants might get upset and emotional when they encounter real fistula clients during training. It might be useful to talk with the participants about this at this stage. Ensure them that you will be available if they need extra emotional support from you during real counseling sessions. This point should be reiterated before and during the clinical practicum as well.

7. Select the next group to perform their role play, and repeat Steps 1–6. Repeat until all groups have performed their role plays.

Activity 5: Discussion *(10 minutes for each of five stages)*

1. Summarize the role plays by asking the following questions:
   - What did you learn from this session?
   - How could you apply what you have learned in your own work setting?
2. Be prepared to conduct your own demonstration role play, in case key steps or skills need to be reinforced.

TRAINING TIP

The role plays will work best if each group is able to practice in front of the others and get feedback. However, this takes more time, particularly if there are many participants in the training. The groups can practice their role plays at the same time if there is enough space and if there are enough trainers to supervise each group. However, you should still have one group demonstrate for the others, and you should still conduct a large-group discussion and collect feedback for that role play. After the participants present their role plays, the trainer should first identify the aspects that were done well, then identify those that were not done very well and show how to do better.

During this session and the next two sessions, the time available for the practice sessions will vary. In this session, the role-plays will take longer because the participants are unfamiliar with the process. Subsequent practice sessions will take less time, as the participants get used to the format and improve their skills. Be flexible in allotting time for role-play practice; it is one of the most important aspects of the entire training. Be sure to remind the participants to use the relevant counseling checklist during their counseling practice.

(*Note:* Including the videotaping option will add five to 10 minutes to the time required for the exercise.)

PART C: COUNSELING WOMEN WITH SPECIAL NEEDS

Time: 55 minutes

Activity 1: Brainstorm/Discussion *(5 minutes)*

1. Ask the participants to make a list of women whose circumstances force them to deal with additional physical or daily concerns, not necessarily related to fistula.
2. Write the participants' comments on the prepared flipchart entitled "Women with Special Needs," and post the flipchart on the wall.

Activity 2: Presentation preparation *(10 minutes)*

1. Distribute Participant Handout 6-K.
2. Divide the participants into six groups and randomly assign one special need from the handout to each group.
3. Ask each group to develop a five-minute presentation on counseling for women with the special need assigned to their group.
4. Distribute flipchart paper, markers, and/or transparencies to each group.
5. Walk around the room and offer help as the participants develop their presentations.

Activity 3: Presentation *(30 minutes)*

1. Ask for a volunteer to serve as timekeeper.
2. Ask each group to give their presentation, making sure that the groups do not go beyond the five-minute time limit.

Activity 4: Discussion *(10 minutes)*

1. Summarize the presentations by asking the following questions:
   - What did you learn from this session?
   - How could you apply what you have learned in your own work setting?

TRAINING TIP

Participant Handout 6-K does not address all types of clients with special needs. Encourage participants to think of women they have encountered who might have had special needs and the solutions/counseling approaches that were used or could be used to address those needs.

In particular, some fistula clients may have experienced violence at the hands of their partners as a reaction to the fistula, may have a fistula caused by rape or sexual assault, or may suffer from the additional trauma of the assault and may have trouble communicating. All women who have experienced violence might suffer from fear, depression, "feelings of going crazy," etc., which might require additional psychiatric counseling, emotional support, and/or medication.

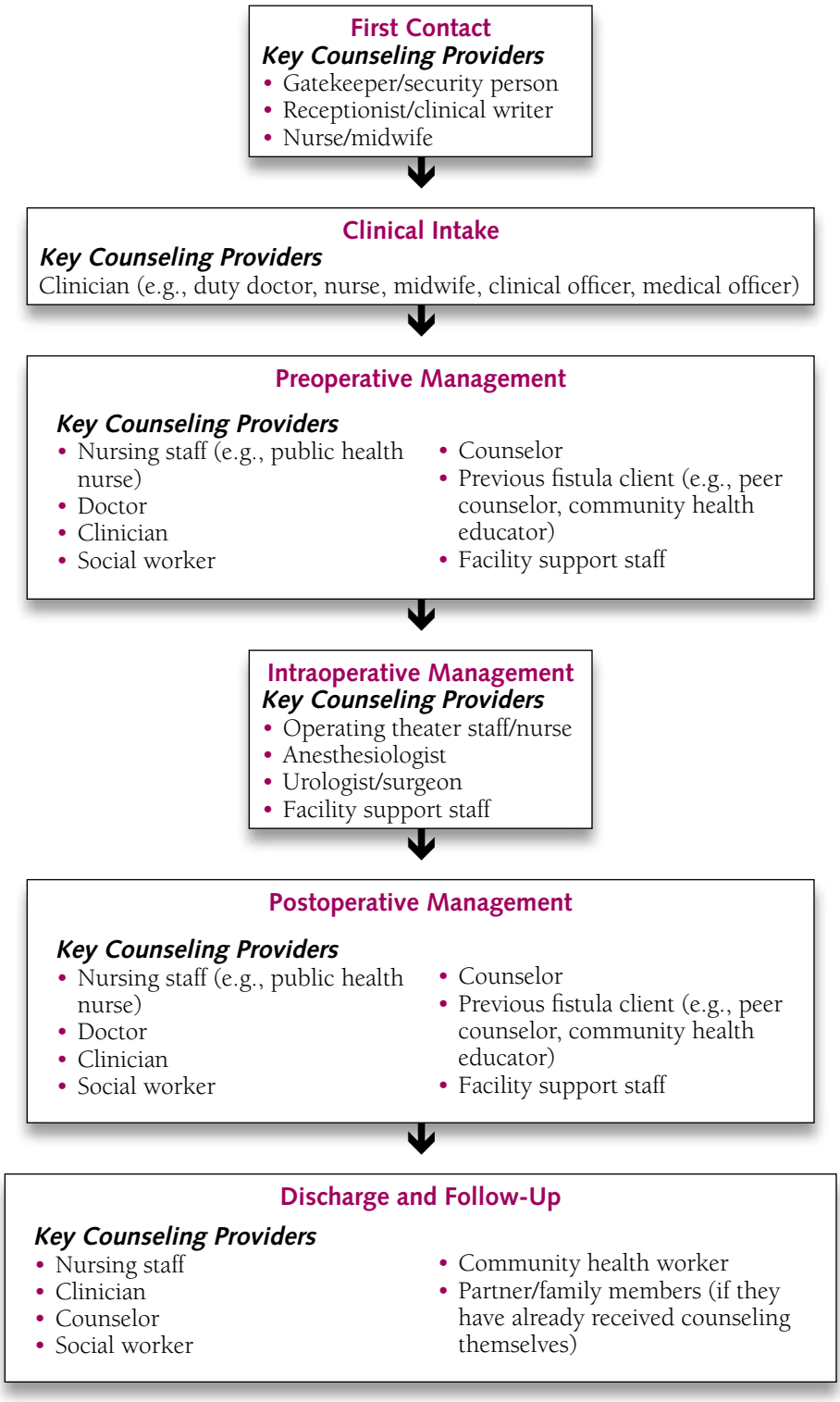
Training participants who work with a significant number of traumatic fistula cases or with women who have experienced sexual violence should be trained in the companion module to this counseling curriculum for women who have experienced traumatic fistula.

Refer to page 139 of the traumatic fistula supplement for additional points to discuss at this point in this activity.

Session 6
Handouts

Participant Handout 6-A

Stages of Service Delivery



Adapted from: The ACQUIRE Project and EngenderHealth. 2005. *Report of fistula counseling experts' meeting: March 29 & 30, 2005, Kampala, Uganda.* New York.

Participant Handout 6-B

Counseling the Fistula Client

Characteristics of Counseling:

- Focuses on helping individuals make choices and manage the emotions associated with their situation
- Goes beyond just giving facts by enabling clients to apply information to their particular circumstances and to make informed choices
- Includes a discussion of feelings and concerns because they are relevant to the client's choices, particularly regarding sexual behavior, reproductive health, and fertility

Counseling always involves two-way communication between the client and the provider, in which each spends time talking, listening, and asking questions.

WHAT IS COUNSELING:

Counseling is a two-way interaction between a client and a health care provider, to assess and address the client's overall health needs, knowledge, and concerns, regardless of what type of health service the provider works within or what health care service the client is seeking.

In integrated sexual and reproductive health counseling, the provider's tasks or responsibilities are to:

- Help clients assess their own needs for a range of health care services, information, and support
- Provide information appropriate to the client's identified problems and needs
- Assist clients in making voluntary and informed decisions
- Help clients develop the skills they will need to carry out those decisions

Adapted from: EngenderHealth. 2003. *Comprehensive counseling for reproductive health: An integrated curriculum—Participant handbook.* New York. Page 9.

Note: Every individual who interacts with a client in a health facility has a role to play in helping the client feel more comfortable. Although some staff have not received formal counseling training (e.g., gatekeepers, clerks, and receptionists), they can and should be oriented to issues affecting fistula clients. Activities such as whole-site training (WST) can be used to address this need (see Appendix I).

Special Counseling Needs of the Obstetric Fistula Client

Information/Education

Up-to-date information and education about fistula and related care should be shared by providers in language that the client will understand and using simple, clear messages. A fistula client will need information in order to:

1. Understand what caused her condition (to dispel any myths or misperceptions) so that she can participate in the management of her condition)
2. Understand the type of fistula she has and the degree and extent of her injury, preferably with the help of a diagram
3. Understand the scope of treatment and success rates, risks, and benefits
4. Know about the availability of fistula repair
5. Understand the possible outcomes of treatment
6. Understand her own role in managing her condition
7. Have clear preoperative and postoperative instructions
8. Understand the importance of her own personal hygiene
9. Become involved in client-support groups within the facility
10. Be exposed to fistula success stories
11. Understand possible preoperative and postoperative complications
12. Understand the issues in reproductive health and sexual rights (including family planning) that might affect her
13. Understand her fertility potential after treatment
14. Understand her family planning options
15. Understand options if repair either is not possible or has been unsuccessful
16. Understand how to care for herself after surgery, including how to maintain good nutrition, how to cook her own food, and how to ensure good personal hygiene
17. Understand the importance of antenatal care in the prevention of fistula, as well as how and where to go for care
18. Understand how to care for herself and where to go for care during any subsequent childbirth (e.g., the need for her next delivery to be in a facility)
19. Use her own knowledge and experience in bringing other fistula clients to facilities
20. Contact community organizations that work with women with fistulas and tap into income-generating activities and educational opportunities

Emotional Support

Counselors will need to ensure that a fistula client:

1. Feels welcome at the facility
2. Has her privacy and confidentiality maintained
3. Feels comfortable with staff and other clients at the facility
4. Feels comfortable discussing feelings, concerns, questions, and needs
5. Feels empowered
6. Has her fears dispelled
7. Has her feelings, concerns, questions, and needs addressed
8. Has adequate support (emotional, physical, and material) before and after repair, regardless of the surgical outcome
9. Understands that she is not the only one with this condition
10. Has coping skills to manage depression or other emotional consequences of fistula

Clinical Management

Health systems should ensure that fistula clients have:

1. Easy access to health services
2. Access to quality treatment/surgical repair for fistula, with no delays
3. Care that is provided with empathy and love
4. Well-trained and competent health care providers
5. Quality nursing care
6. Confidence that they will be treated with respect, that their confidentiality and privacy will be maintained, and that they will be treated as partners in their care and treatment
7. Quality care to address co-morbid conditions both preoperatively and postoperatively (e.g., physiotherapy [if necessary], special diet [if necessary in preparation for surgery], etc.)
8. Access to client-support groups within a given facility
9. Access to community self-help organizations, where available
10. Access to quality follow-up services after discharge
11. Access to quality emergency obstetric care services (before and after successful repair)
12. Access to other sexual and reproductive health services after repair, including family planning services

Adapted from: The ACQUIRE Project and EngenderHealth. 2005. *Report of fistula counseling experts' meeting: March 29 & 30, 2005, Kampala, Uganda.* New York.

Participant Handout 6-C

Stages for Counseling the Obstetric Fistula Client

FIRST CONTACT

- Ensure a warm welcome.
- Provide directions to appropriate unit.
- Maintain empathy/ respect.
- Demonstrate understanding of client's condition (physical, emotional, etc.).
- Ensure confidentiality (when possible).

Note: The client's needs and the appropriate counseling messages will vary, depending on whether the client has already been diagnosed with fistula or is presenting for the first time.

→

CLINICAL INTAKE

- Ensure privacy and dignity.
- Assess the client's ability or capacity to give and receive information.
- Explore the client's needs and feelings.
- Examine the client's values and life plans.
- Based on the client's condition, provide information about the following, as appropriate:
  - Exams and findings
  - Present condition and its causes (including dispelling any myths or misconceptions about fistula)
  - Possibility of treatment and/or treatment options (e.g., if client is told she has to wait for surgery, she should understand why)
  - Self-care
  - Length and outcome of treatment
  - Success rates, possible side effects, complications, and risks
  - Success stories (e.g., past clients could be there to talk with clients, or facility could show video/pictures of cured fistula clients with children)
  - Client social support groups within facility
  - If client's condition not treatable, provide information on community support networks and discuss how she will go about her life

Note: Partners and/or family members should be involved in counseling from this stage on (either with client or separately).

→

PREOPERATIVE MANAGEMENT

- Ensure a warm welcome.
- Introduce the fistula client to other clients in the ward.
- Maintain emotional support by:
  - Providing positive, empathetic verbal and nonverbal communication
  - Alleviating fears regarding surgery
- Based on the client's condition and discussion with the surgical team looking after her, provide information about the following, as appropriate:
  - Description of procedure (including dangers, possible complications, success rates)
  - Success stories
  - Client's role in management of condition

↓

Adapted from: The ACQUIRE Project/EngenderHealth. Report of the Fistula Counseling Experts' Meeting: March 29 and 30, 2005, Kampala Uganda.

Stages for Counseling the Obstetric Fistula Client *(continued)*

INTRAOPERATIVE MANAGEMENT

- Ensure respect and dignity.
- Maintain emotional support by providing:
  - Positive, empathetic verbal and nonverbal communication
  - Alleviating fears regarding surgery
  - Reassurance/comfort/hope
- Based on the client's condition and discussion with the surgical team looking after her, provide information about the following, as appropriate:
  - Information on the type of anesthesia to be used, risks of anesthesia, and pain
  - Reiteration of steps of procedure

Note: Counseling needs during the intraoperative period vary, depending on whether the surgery is conducted under general or spinal anesthesia.

POSTOPERATIVE MANAGEMENT

- Ensure a warm welcome back!
- Maintain emotional support by:
  - Providing reassurance
  - Addressing the client's feelings
- Based on the client's condition, provide information about the following, as appropriate:
  - Outcome of surgery
  - Self-care
  - Catheter care
  - Position and mobility
  - Nutrition
  - Pain relief
  - Complications/danger signs
  - Physiotherapy, if necessary
  - Necessary period of abstinence from sex
  - Need for careful antenatal care and hospital delivery (likely by cesarean operation) for future pregnancies
  - Availability of sexual and reproductive health services and rights (including family planning)

Note: Partners and/or family members should receive counseling at this stage so that they acquire a complete understanding of what they will need to do to assist in postoperative management. Depending on specific health facility norms, the family might be involved immediately postoperation in helping to bring food and cook, finding water for cleaning, etc.

DISCHARGE AND FOLLOW-UP

- Explore the client's feelings, questions, and concerns after the procedure—provide support and encouragement.
- Remind the client of possible side effects, risks, and warning signs, and develop a plan in case complications/warning signs occur.
- Tell the client how to take care of herself at home, including:
  - Necessary period of abstinence
  - Delaying pregnancy
  - Managing stress incontinence
- Give client written postprocedure information.
- Remind the client of the importance of follow-up.
- Discuss available contraceptive methods, as appropriate.
- Discuss reproductive tract infections and sexually transmitted infections, including HIV.
- Assess the need for additional counseling or referral for other reproductive health needs or nonmedical issues.
- Provide links to community organizations, where available.
- Discuss income-generating activities and educational opportunities, if available.

If surgery was unsuccessful:

- Based on the client's condition, provide information about the following, as appropriate:
  - Why surgery was unsuccessful
  - Possible future surgery (whether possible or impossible, and if possible, when and where)
  - Possible future options
  - Personal hygiene and good nutrition
  - Managing incontinence (e.g., special exercises)
  - Messages about delaying pregnancy/family planning/contraceptive choices (if desired) (especially while she waits for next operation)
  - Possible complications and/or infection

Participant Handout 6-D

10 Tips for Improving Counseling Services for Obstetric Fistula Clients

Participants at an experts' meeting on counseling women with obstetric fistula (see footnote) shared a series of counseling tips. Listed below are 10 of their suggestions:

1. Many women with fistula are not literate and have not had the benefit of a formal education. For this reason, **drawing a diagram to help explain what caused the fistula** might be more useful in helping women understand their condition better than would sharing informational materials or using medical terminology to try to explain the condition. In some situations, using analogies (such as showing a torn piece of paper or a paper cup with a hole in it, to demonstrate leakage) might also be helpful.

2. Many fistula clients are shunned by family members or communities; others isolate themselves. For this reason, **initial counseling should include key messages of acceptance** to help women "find their voice" again and regain a sense of self-esteem.

3. In some settings, **providers themselves hold attitudes or beliefs that further stigmatize fistula clients**. Counseling training should include a focus on addressing providers' biases and potential misperceptions about women with obstetric fistula.

4. Women who are **former fistula clients are often excellent facility- or community-based counselors**. With a small amount of training, they can become valuable messengers.

5. **Sharing stories about women who have had a fistula successfully repaired can be an important strategy in preoperative counseling**. These stories can help to allay fears and provide hope when women are at an especially vulnerable point in the treatment process.

6. In situations where fistula clients speak a different language than staff, **former fistula clients can serve as effective translators**.

7. **Involving family members and/or partners in counseling** can be key to a client's overall success. Family can provide critical support for the client's emotional, material, and clinical needs, both preoperatively and postoperatively. Family members and partners may be counseled together with the client or during a separate session, depending on the information being discussed and their preferences.

8. As former fistula clients begin the process of reintegration, **existing community structures and support groups can help to ease the process of reentering society**.

9. **Counselors can help to empower women by emphasizing the woman's role in her own recovery process**. When they are aware of their progress in healing and in taking charge of their own care, clients often begin to acquire a sense of control over their lives again.

10. To ensure that their clients' future health care providers know about the client's fistula repair, **some facilities have created personalized cards for clients that include the surgeon's notes**. The card is given to the client when she leaves the facility, and she is instructed to bring it with her if and when she seeks care again. This helps the client communicate medical information, relay accurate details, and "own" the experience in a way that she might not otherwise.

Adapted from: The ACQUIRE Project and EngenderHealth. 2005. *Report of fistula counseling experts' meeting: March 29 & 30, 2005, Kampala, Uganda*. New York.

Participant Handout 6-E

Overview of Clinical Intake

NOTE

High clinical suspicion is the key to prompt and accurate diagnosis.

History Taking

At a minimum, history taking should include the following:

- Age, parity, and past obstetric history
- Any history of genital cutting
- Number and sex of children, dates of delivery, and their fate
- Menstrual history, especially since last delivery
- Personnel assisting last pregnancy and delivery
- Duration of labor and how it was managed
- The baby's lie and presentation, if known
- Mode of delivery and surgical intervention, if any (e.g., episiotomy, symphisiotomy, destructive surgery)
- Outcome for the baby
- Onset and duration of symptoms for urinary or fecal incontinence
- Problems with gait or mobility, if any
- Past medical and surgical history, including allergies, if any
- Persons providing client's current care and care after surgery
- Marital and social history, including any problems as a consequence of fistula

Diagnostic Criteria for Vesicovaginal Fistula

When taking a client's history, keep in mind that the quality of the preliminary diagnosis will be improved if one or more of the following descriptive criteria are utilized:

- Clients typically present after a difficult delivery, complaining of continuous, painless drainage of urine. The presentation is usually within the first three days after obstructed labor, but it may be as late as seven days.
- Some clients report exacerbation during physical activity. (This can lead to a misdiagnosis of stress incontinence.)

- If the fistula is small, leakage might be intermittent, depending on bladder distention or physical activity.
- Some clients may complain of vaginal discharge or blood in urine.
- If there is concurrent ureteric involvement, the client might experience nonspecific symptoms such as fever, chills, flank pain, or gastrointestinal symptoms that are caused by kidney infection.

Diagnostic Criteria for Rectovaginal Fistula

When taking a client's history, keep in mind that the quality of the preliminary diagnosis will be improved if one or more of the following descriptive criteria are utilized:

- A few clients have no symptoms.
- Most clients report passage of flatus or stool through the vagina.
- Clients may report symptoms arising from vaginitis or cystitis, such as vaginal discharge or frequent and painful urination.
- At times, a foul-smelling vaginal discharge develops, but obvious stool might not be seen from the vagina unless the client has diarrhea.
- The clinical client might also have fecal incontinence due to associated damage to the anal sphincter.

Physical Exam

The client's physical exam may be conducted, using a gentle technique, by the counselor, but only if it is within the counselor's training and job responsibilities. It is as important to seek consent and prepare the woman for the physical exam as for surgery, including for the possibility of experiencing discomfort or pain during the examination. Many women are frightened, and they will need reassurance and an explanation of why the examination or procedure is being performed and what to expect.

The physical exam should cover the woman's general condition, as well as any condition associated with fistula. The exam should be carried out using gentle technique and should include:

- Checking vital signs (e.g., pulse, blood pressure, respiration, and temperature)
- Noting signs of possible malnutrition or anemia
- Examining the abdomen gently
- Assessing limb weakness, foot drop, abnormal gait or mobility, or contractures
- Inspecting the vulva, vagina, perineum, and thighs to detect any signs of:
  - Skin inflammation/ammoniacal dermatitis
  - Excoriation or ulceration of the perineum and thighs
  - Infection of the skin
  - Fecal contamination
  - Genital cutting, episiotomy, or tears

- Conducting a gentle digital and speculum examination[1] (which can be conducted either during the physical exam or during the preoperative period, depending on the surgeon's preferences), to detect:
  - Any other pelvic abnormality
  - The presence or absence of the uterus
  - The presence of necrotic tissue that might require removal
  - The presence and severity of vaginal scar tissue
  - The location and number of fistulas and the approximate size of each circumferential defect
  - Any urethral involvement
  - The presence, location, and size of any rectovaginal fistula (RVF) and the presence of scarring, anal involvement, and stricture
  - The presence of bladder stones[2]

Diagnostic Criteria for Vesicovaginal Fistula

When conducting the physical exam, keep in mind that the quality of the preliminary diagnosis will be improved if one or more of the following descriptive criteria are utilized:

- Pooling of fluid in the vagina may be noted. The fluid should be sent for analysis if the diagnosis is unclear.
- A careful speculum exam to see the entire anterior vaginal wall should be performed to identify the fistula. In many cases, the fistula is readily visible. The location of the fistula in relation to the vaginal apex and bladder trigone should be inspected and the quality of the surrounding tissue (inflammation, edema, scarring, or infection) noted.
- In some cases of small fistula, no obvious hole may be visible. Bimanual exam with careful palpation of the anterior wall might locate the fistula, with its surrounding area of induration.
- If no fistula is noted despite high clinical suspicion, a simple dye exam test of the bladder can be performed in the consultation room. The bladder is filled with a liquid dye (normal saline with indigo carmine) using a urinary catheter, and repeat pelvic exam with a speculum is performed to visualize the anterior wall. The client is asked to cough and bear down, and the leakage of liquid dye confirms the location of the fistula.
- If this test is negative, a tampon should be inserted and the client can then be asked to perform 10–15 repetitions of a maneuver that increases intraabdominal pressure, such as climbing steps or jumping in place. The presence of a fistula can then be confirmed when the tampon is removed and dye can be seen beyond the most distal edge of the tampon.
- A variation of this technique is the double-dye test, in which the client is given a dye orally (phenazopyridine or pyridium), the bladder is filled, and a tampon is inserted. The presence of blue staining (indigo carmine) suggests vesicovaginal or urethra-vaginal fistula, while red staining (pyridium) suggests ureterovaginal fistula.

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[1] *Note:* For the speculum examination, some surgeons will put the woman in exaggerated left-lateral position.

[2] If bladder stones are suspected, the diagnosis can be made by passing a small metal catheter or uterine sound through the urethra; however, some surgeons prefer to do this at the time of the operation, because it can be uncomfortable for the client.

- In some settings, the woman is examined under anesthesia in a separate session, and a dye test is used to identify fistula. In other settings, this is done at the beginning of the main operation and is followed immediately by definitive surgery in the same session.

Diagnostic Criteria for RVF

When conducting the physical exam, keep in mind that the quality of the preliminary diagnosis will be improved if one or more of the following descriptive criteria are utilized:

- Physical examination is essential to confirm the diagnosis and estimate the size and location of the fistula, evaluate the function of the sphincters, and assess the possibility of inflammatory bowel disease or local neoplasm.
- Outpatient examination usually consists of a rectovaginal examination (visual and palpation). The fistula opening may be seen as a small dimple or pit and occasionally can be gently probed for confirmation. The examination might include proctoscopy or proctosigmoidoscopy, if this is available.
- Placing a vaginal tampon, instilling methylene blue into the rectum, and examining the tampon after 15–20 minutes can often establish the presence of RVF. If the tampon is unstained, another part of the gastrointestinal tract may be involved.

Laboratory Tests

Screening

The following tests may be used to rule out other abnormalities and to formulate a suitable treatment plan:

- Hemoglobin, sickling test, and blood typing
- Stool exam for parasites
- An intravenous urogram, especially for women with apparent ureterovaginal fistula or high vesicovaginal fistula/bladder neck involvement
- Urinalysis and culture to rule out coexisting urinary tract infection
- Blood urea, electrolyte, and creatinine to assess kidney function
- Complete blood cell count to rule out systemic infection
- Wet mount for vaginal infections
- Screening for sexually transmitted infections
- Immunization status (check records if available); any needed vaccinations should be provided

Additional tests for vesicovaginal fistula (performed at the surgeon's discretion) include:

- Cystoscopy to see the fistula and assess its location in relation to the ureters and trigone, ensure bilateral ureteral patency, and exclude foreign body (or suture placement) in the bladder
- A biopsy of the fistula tract and urine cytology, especially in clients with suspected urogenital malignancy
- Radiologic studies prior to surgical repair of a vesicovaginal fistula to fully assess the fistula and exclude the presence of multiple fistulas

- An intravenous pyelogram to exclude concurrent ureterovaginal fistula or ureteral obstruction
- A targeted fistulogram, if conservative therapy including expectant management, continuous bladder drainage, fulguration, or fibrin occlusion therapy is to be recommended.

Additional tests for RVF (performed at the surgeon's discretion) include the following:

- Flexible endoscopy (sigmoidoscopy or colonoscopy) might be performed to fully evaluate the possibility of inflammatory bowel disease.
- When inflammatory bowel disease is in the differential diagnosis, endoscopy with biopsies must precede any operative approach to the fistula because the treatment depends on the diagnosis.

Explanation, Discussion, and Consent

Once the results of the preliminary investigations are available, using simple language, terms, and visual aids, the counselor should explain every aspect (the treatment options, details of the operation and postoperative period, and possible long-term sequelae) to the woman and to her partner and family, if possible and if the woman so desires. Involving the partner and family in receiving this information and making decisions is likely to increase their support for the woman after the operation and during future pregnancies.

The woman and her partner or family might need some time to consider the various options before making a decision. If the woman chooses to have the operation, her informed consent for the procedure should be obtained and formally recorded. It is important that the woman makes the decision herself and that she gives her consent freely.

Classification

Fistulas are classified in two ways: (1) by their surgical classification and (2) by the possible degree of difficulty of their repair (WHO, 2005). Both are based on the degree of involvement, or not, of the closing mechanism, since this has consequences for the operative technique and the prognosis of the repair.

The *surgical classification* refers to the type of surgical repair that might be required. There is no standardized classification system for obstetric fistula; a number of such systems are used. One example (see table at top of page 164) shows how the operative technique becomes progressively more complicated based on the type, from type I to type IIBb. The same principle applies to classification by the size of the fistula, which ranges from small to extensive.

Fistulas are also divided into two categories based on the *degree of anticipated difficulty of the repair (see table at bottom of page 164):*

- Good prognosis/simple fistula that can be repaired by surgeons fully trained and competent in undertaking uncomplicated fistula repairs
- Uncertain prognosis/complicated fistula that require referral to, and repair by, a specialist fistula surgeon

CLASSIFICATION OF FISTULAS BY TYPE OF SURGERY REQUIRED, BASED ON THEIR ANATOMIC/PHYSIOLOGIC LOCATION

Type I	Fistula not involving the closing mechanism		
Type II	Fistula involving the closing mechanism		
	A	Without (sub)total urethral involvement	
		a	Without circumferential defect
		b	With circumferential defect
	B	With (sub)total urethral involvement	
		a	Without circumferential defect
		b	With circumferential defect
Type III		Miscellaneous (e.g., ureteric and other exceptional fistula)	
Subclassification of fistula by size			
Small	<2 cm		
Medium	2–3 cm		
Large	4–5 cm		
Extensive	6 or more cm		

Source: Waaldijk, 1995.

DEGREE OF ANTICIPATED DIFFICULTY OF THE REPAIR FOR DIFFERENT FISTULA CONDITIONS

Defining criteria	Good prognosis/simple	Uncertain/complicated
Number of fistula	Single	Multiple
Site	Vesicovaginal fistula (VVF)	Rectovaginal fistula (RVF), VVF/RVF, involvement of the cervix
Size (diameter)	<4 cm	≥4 cm
Involvement of the urethra/continence mechanism	Absent	Present
Scarring of vaginal tissue	Absent	Present
Presence of circumferential defect (complete separation of the urethra from the bladder)	Absent	Present
Degree of tissue loss	Minimal	Extensive
Ureter/bladder involvement	Ureters inside the bladder, not draining into the vagina	Ureters draining into the vagina; bladder may have stones
Number of attempts at repair	No previous attempt	Failed previous attempts

Source: WHO, 2005.

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Participant Handout 6-F

Overview of Admission and Preoperative Management

Medical Problems Associated with Fistula

Early diagnosis and treatment of fistula is rare in less-developed countries. Clients who come to a fistula repair center may have had a fistula for months or even years, and often they are suffering from malnutrition and anemia, which must be improved before surgery. Some clients will have lower limb weakness, muscular contractures, and foot drop, for which physical therapy and psychological counseling need to begin preoperatively and continue postoperatively.

Severe Malnutrition and Anemia

Because most women with genital tract fistulas are poor, they might also suffer from malnutrition and anemia. They might have suffered prolonged labor complicated by postpartum hemorrhage. In addition, they might have been living as social outcasts for a long time, with little food and money. They might also be infested with intestinal parasites.

- For women who are symptomatic or hemodynamically compromised from anemia, a blood transfusion and/or hematinic supplements might be indicated.
- Women who are severely malnourished need nutritional assessment on admission and a high caloric, nutritionally balanced diet.
- Iron, vitamin supplements, and broad-spectrum antihelminthic drugs might also be necessary.

Infection

Depending on symptoms and local disease prevalence, women should be screened for infection (scabies, intestinal parasites, and tuberculosis) and treatment should be started prior to surgery.

- If a woman presents soon after the causative obstructed labor, care should be taken to screen for and treat vaginal and/or uterine infections.
- Where reproductive tract infections and sexually transmitted infections, including HIV and AIDS, are prevalent, relevant assessment, screening, and treatment should be performed.
- Women with excoriative dermatitis may be treated with antibiotics or emollient creams (e.g., topical zinc oxide creams) preoperatively, but treatment should not delay surgery. Dermatitis will disappear once the fistula is closed and there is no longer urinary irritation to the skin.

Impaired Renal Function

Assessment of renal function is indicated, especially in women with ureteric fistula.

- A routine intravenous urogram is not necessary for all clients, but it might be needed to confirm the diagnosis and location of a ureteric fistula, and it could provide information regarding the presence of a hydroureter and/or hydronephrosis.
- If a woman's renal function might be impaired, blood urea, electrolyte, and creatinine tests should be ordered.

Calculi

Calculi in the bladder and/or vagina are not uncommon in fistula clients. The calculi and any other foreign objects must be removed, either through the fistula or through a suprapubic cystotomy. In the presence of inflammation and infection, antibiotic therapy is recommended and fistula surgery might be postponed.

Foot Drop and/or Altered Gait

Damage to the nerves in the legs causes some women to have difficulty walking, and this may be made worse by the development of contractures. These women might need extensive physical rehabilitation that begins before surgery and will be completed after treatment.

Anxiety and Depression

Fistula clients tend to have a poor self-image and low self-esteem, often believing that their condition is unique. They may be ashamed and downcast, and might avoid eye contact when speaking with others. In some cases, the woman has been abandoned by her partner, who may have left to remarry. In such situations, a woman is typically unable to support herself financially and will move in with her parents or another family member. While in some cases family members take the woman in graciously, in others she is treated like a prisoner. Women sometimes isolate themselves out of fear and the shame of smelling bad, abandoning their homes before their partners have the chance to leave them. Some women also are rejected by and live in isolation from their broader communities. Some are forced into commercial sex work or other forms of unskilled labor to earn a living.

A woman who has a fistula is often nonliterate and may be unaware of her own condition and of the possibility that fistula can be managed or repaired. She is often nervous in unfamiliar surroundings and may feel intimidated by the medical or nursing staff.

- Careful psychological counseling should be made available throughout the treatment process and after discharge to women who need it.
- Any woman who presents with fistula needs a gentle but practical and simple explanation of her condition. The counselor should explain the etiology (and dispel any myths or misperceptions), the treatment options, success/failure rates, self-management, treatment plans, and issues related to future fertility. The woman needs to know about the possibilities of surgical success and failure and about the possibility of further surgery in the future.

Preoperative Preparation

Nutrition

Before the surgery, the fistula client maintains a normal diet until the afternoon of the day before the operation. Then she receives oral fluids in the evening. Alternatively, the client might be advised to eat lightly for three days prior to surgery.

The client should ingest nothing orally after midnight on the night before the surgery.

Elimination

- Bowel preparation: The regimen for enemas varies, depending in part on whether the surgery is for vesicovaginal fistula or rectovaginal fistula, but two frequently used regimens are:
  - Two enemas, one at 10:00 p.m. and one at 6:00 a.m., on the day before and the day of the surgery
  - One enema twice a day for two days before surgery

Hygiene

In preparation for surgery, fistula clients should be instructed in careful perineal hygiene.

In addition, the perineal and perianal skin should be cleansed using a product specifically designed for this purpose. Frequent cleaning with soap and water should be avoided, as it might irritate perianal skin and worsen the damage caused by fecal/urine leakage.

Medications

Prophylactic antibiotics may be provided. In addition, a sleep aid may be provided the night before surgery, and an antianxiety medication may be provided just before the woman goes into surgery.

Blood

Clients might be asked to arrange for two or more units of blood, in case the surgery requires a transfusion, but most do not.

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Participant Handout 6-G

Overview of Surgical Intervention

Vesicovaginal Fistula

Symptomatic vesicovaginal fistula (VVF) requires appropriate treatment because spontaneous closure is uncommon. Appropriate treatment depends on a variety of factors, and different fistula classification systems place different degrees of emphasis on the various factors. However, there is widespread agreement that the most germane factors are fistula size, site, and scarring. Others factors include the number of fistula and previous attempts at surgery, the length and breadth of the rest of the urethra and vagina, bladder capacity, urinary stones, duration since the event that caused the fistula, severity of symptoms, quality of surrounding tissue, and the clinician's experience and surgical skills.

Conservative Management

To prevent fistula formation, or to encourage very small fistula to close spontaneously, it is important that all women who have survived prolonged or obstructed labor, with or without a cesarean operation, be treated according to the following regimen immediately after childbirth or as soon as they arrive at a health care facility:

- An appropriate size (Foley 16–18) indwelling catheter should be inserted to enable drainage of urine, from 14 days to 4–6 weeks.
- The perineum and vagina should be cleaned with salty water (sitz baths), or a solution of mild detergent in water, twice a day.
- The woman should be encouraged to drink a large volume of fluids, around 4–5 liters per day.
- The vagina should be examined as soon as possible, by speculum, and any necrotic tissue should be gently excised.
- Any infection should be treated according to local protocols, and routine prophylaxis against urinary tract infections should be used.
- If the treatment is successful, the woman and husband should be advised on family planning, antenatal care for future pregnancies, and the need to give birth in a facility with the capacity for cesarean operations.
- If the treatment is not successful, the woman and husband/family should be advised on treatment options.

The spontaneous closure of 15–20% of simple or small fistulas can be achieved by conservative means, provided the women are treated immediately after or within a few days of giving birth. In these cases:

- The regimen is identical to that for women who have survived prolonged or obstructed labor, except that continuous bladder drainage by catheter should be maintained for a minimum of four to a maximum of six weeks, according to local protocol.

- Any necrotic tissue should be regularly and gently debrided, if necessary, even if the woman will eventually require surgery.
- Women for whom the above regimen is successful may be discharged when their vagina is clean and has completely healed. The woman and husband should be advised on family planning, antenatal care for future pregnancies, and the need to give birth in a facility with cesarean operation facilities.
- If the above regimen is not successful, the woman and husband/family should be advised on treatment options.
- Persistent, large, or complex fistulas are best treated with surgical intervention.

Surgical Management

Appropriate timing for fistula repair has been a controversial matter. Traditionally, an interval of three months has been recommended between the event that caused ischemic tissue necrosis (e.g., obstructed labor) and the fistula repair. However, there is little scientific evidence to support this recommendation. More current thinking recommends an earlier repair, although individualized to each client. Surgery is delayed only until surrounding tissue inflammation and infection have resolved or been treated and necrotic tissue has been removed. Occasionally, antibiotics and estrogen and/or other steroids have been used to facilitate healing during this period.

Most vesicovaginal fistulas can be surgically corrected using a vaginal approach, which is associated with success rates of up to 90%. Advantages of this procedure include a short operating time, low morbidity (both during and following the procedure), and low risk of ureteral injury.

Although most vesicovaginal fistulas can be surgically corrected via the vaginal approach, the abdominal route is preferred for fistulas that are high, large, or inaccessible, for complex or multiple fistulas, and for those that have concurrent uterine or bowel involvement or need urinary diversion.

Rectovaginal Fistula

Medical Management

Local care, including drainage of abscesses and antibiotic therapy, can be used effectively to treat some fistulas caused by obstetric, operative, or other trauma and fistulas complicated by secondary infection or of infectious origin. Tissues should be allowed to heal for 6–12 weeks, although some surgeons operate earlier. Dietary modification and supplemental fiber can greatly diminish symptoms during this period. Many rectovaginal fistulas resulting from obstetric or operative trauma heal completely, requiring no further therapy. If the fistula persists after this period of treatment, and the tissues have become supple as inflammation is controlled, repair may be considered.

Surgical Management

Highly symptomatic fistulas occasionally require a temporary diverting colostomy for the client's comfort, but this may add to her stress and become inconvenient. The colostomy is not curative but is a temporary help. It is usually performed if repair of a rectovaginal fistula is planned within two weeks, and the colostomy closure is projected to be within four weeks after successful fistula repair.

All surgical interventions to be considered include the following aspects:

- Anesthesia—general or spinal:
  - Spinal anesthesia with a long-acting agent is being used more and more frequently because it is easy to learn how to administer the drug, the technique does not need intensive intraoperative and/or postoperative monitoring, it is as effective as general anesthesia, does not require electricity, and it is safe and inexpensive.
- I.V. fluids
- Prophylactic antibiotics (These may only be given preoperatively.)
- Examination under anesthesia (If an examination was not performed before surgery, it may be performed at the beginning of the operation, immediately before the definitive surgery.)
- In case of a combination fistula:
  - Surgeons might start with RVF repair and then perform VVF repair; or they might begin with the VVF repair and then complete the RVF repair.
  - Some surgeons will repair both fistulas at the same time; others might choose to repair one fistula at a separate surgical session.
- Position for vaginal entry:
  - Exaggerated lithotomy position is the most commonly used position, but the knee-chest position is also sometimes used. Occasionally, for specific types of fistula, the abdominal approach is necessary, with the client in a supine position.

Exaggerated Lithotomy Position

Source: Wall, L. L., et al., 2002, p. 917.

- The length of the surgery usually varies from one to four hours.

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Participant Handout 6-H

Overview of Postoperative Management

Immediate Postoperative Care: First 24 Hours

Regular observations and timely, appropriate action are very important. Assess:

- Hemodynamic status: Check pulse, blood pressure, pallor, and temperature.
- Respiratory rate
- Mental alertness
- Primary hemorrhage: check all potential bleeding sites (vaginal pack, labial graft site, abdominal incision, drainages)
- Fluid input/output chart: oral and I.V. fluids, urine output, and other drainage
- If catheter(s) are in place (e.g., ureteric, urethral), check to see that they are draining as expected
- Color of urine

Use of prophylactic antibiotics varies widely, from none to a single I.V. preoperative dose, to multiple additional postoperative doses. Common protocols for prophylaxis include:

- Extencilline (long-acting penicillin) in a single dose
- Sulfamethoxazole/trimethoprim or amoxicillin for seven days
- Parenteral antibiotics (usually sulfamethoxazole/trimethoprim) for 24 hours, then continued orally for another week

Finally, pain assessment and management are essential, to ensure the client's comfort and pain control with analgesics.

Subsequent Postoperative Care

Urine Drainage

Continuous free drainage of urine will ensure that the bladder is kept empty and will allow the suture line to heal. Therefore:

- Ureteral catheters should be left in place for 7–10 days.
- A urethral catheter should used for continuous drainage for 10–14 days, depending on the type of fistula.
    - Some hospitals will use open catheters that drain into a receptacle, so that there is less danger of bladder distension.
    - Other hospitals promote the use of a Foley catheter with a urine bag to allow easy mobilization.

Catheter Care

It is vital to maintain free bladder drainage after fistula repair and to ensure that the client understands the urgency of this recommendation. Therefore:

- Ensure that the catheter or tubing is not twisted or kinked or blocked by a blood clot. The catheter is to remain in place without tension or pulling on the urethra or bladder. The catheter may be fixed to the client's thigh with tape or to her labium with a suture (during surgery).
- Ensure that the urine bag is not distended (with urine or air), as this will impede drainage of the bladder; backflow of urine could disrupt the repair site.
- Encourage the woman to empty her bag or inform staff if the bag is filled up.
- If blockage of the catheter is suspected, flush the catheter with saline water (sodium chloride 9%) or boric solution (chlorinated lime) or boric acid (BP 1988 Eusol) mixed with purified water. Sometimes the catheter will need to be changed, an action that usually needs to be done in the operating theater.
- Use a larger catheter if significant hematuria is present.
- Avoid a bladder wash if a Foley catheter is used; there is also debate as to whether or not the bulb should be inflated. Bladder wash may distend the bladder too much and disrupt the repair site.
- Bladder training:
  - Some hospitals recommend that, starting a few days before the catheter is removed, the catheter should be clamped for short periods and then for progressively longer periods, to accustom the bladder to distension. Then, if the client is dry, the catheter can be completely removed.
  - Other hospitals find bladder training unnecessary. It might do more harm than good if the bladder becomes inadvertently overdistended, leading to rupture of the repair site. Instead of using bladder training, they recommend removing the catheter and asking the client to voluntarily and gradually increase the length of time she waits before passing urine.
- The catheter should be left in place for a longer period if there are concerns about the integrity of the fistula repair in the postoperative period. A dye test can also be performed. If the dye test is positive, indicating persistent leakage, the catheter should be left in place for 2–3 weeks longer.

Vaginal Pack

If a vaginal pack was used, it should be removed in 24–72 hours, depending on concerns about hemostasis and vaginal scarring/stenosis encountered during surgery.

Antibiotics

Depending on the regimen used, antibiotics may or may not be continued in the postoperative period.

Bed Rest and Mobilization

The client should be encouraged to become fully mobile as soon as possible:

- Women who have undergone simple repairs should be encouraged to move around within a day of surgery.
- Those who had complicated repair, ureteric reimplantation, and so on may need to wait up to seven days after surgery for mobilization.

- The urine bag must be kept empty when the woman is moving around. Care should be taken to prevent a sudden pull on the catheter.

Hydration

- Encourage high fluid intake to enable the woman to produce 2–3 L of urine per 24 hours.
- Monitor her fluid input and output.

Diet

- All women should be started on a fluid diet the day after the operation and should be encouraged to drink copiously.
- A woman who has had a vesicovaginal fistula repair usually will tolerate a soft diet on the first day after the surgery and should progress to a regular diet by the second day.
- Dietary protocols following rectovaginal fistula or complicated fistula repair vary with different surgeons.
- Women who have had a colostomy can follow the diet regimen for vesicovaginal fistula clients.

Bowel Care

- Prevent constipation and undue straining.
- Medications may be used to soften the stools.
- Rectal suppositories should be avoided if the woman had a rectovaginal fistula.

Prevention of Deep-Vein Thrombosis and Pulmonary Complications

- Deep-breathing exercises
- Coughing
- Positioning
- Mobilization
- Pain management

Training in Pelvic Floor Exercises

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Participant Handout 6-I

Overview of Discharge and Follow-Up

The client should be counseled and assisted with:

- Identifying and making contact with community groups that work with women who have fistulas
- Scheduling a follow-up visit and making sure she has the necessary means and transportation to be able to come back for the visit
- Scheduling a home visit with community health nurses, if possible and available
- Recognizing possible danger signs and developing a complication readiness plan
- Understanding the information contained in the Discharge Information Sheet (Handout 6-J).

Complications Following Repair

Early Complications

- Anesthetic complications:
  - From the medications given: dose-related problem; allergic reaction to the medication
  - From the anesthetic procedure: complications largely depend on the type of anesthesia (e.g., general with or without endotracheal intubation; spinal anesthesia)
- Hemorrhage:
  - Primary hemorrhage, which occurs within 24 hours of surgery, is usually from unsecured bleeding points.
  - Secondary hemorrhage, which occurs more than 24 hours after surgery, is due to infection with erosion into a vessel, which occurs one to two weeks after surgery. This may also occur from unrecognized slow or small primary bleeding sites and from trauma to the surgical site.
- Infection:
  - Wound infection
  - Urinary tract infection
  - Respiratory tract infection
- Ureteric complications:
  - Surgical injury
  - Obstruction, edema
- Blockage of catheter due to kinking or blood clot
- Wound dehiscence and failure of repair, usually after the first week or about day nine to 12 postoperatively

Late Complications

- Vaginal stenosis and scarring
  - Stenosis or scarring may occur as a result of the surgery or may be present at the time of surgery.
  - When present at the time of surgery, it is usually situated as a thick band over the posterior vaginal wall. Management of this band of scar tissue is by lateral incision to release the scar.
  - The vaginal pack is left in situ for several days after the fistula repair.
  - A well-lubricated vaginal dilator is used to prevent reformation of the vaginal scar and stenosis. The dilator is very gently inserted and left in place for at least 10 minutes each day for a period of six weeks.
  - When the scar is more extensive, skin grafts or pedicle grafts may be harvested and rotated into the vagina from surrounding tissues (e.g. buttock, labia, thigh) to cover the tissue deficit following incision and excision of scar tissue to establish a normal vaginal caliber.
- Persistent urinary incontinence
  - Incontinence is a significant complication of fistula and is frequently ignored or underestimated.
  - It may be the result of failed fistula repair, undiagnosed ureteric fistula, missed fistula, genuine stress incontinence, detrusor overactivity/instability, overflow incontinence, infection, or bladder calculi.
  - It may be mild or very severe, with the woman complaining of continuous leakage.
  - Further assessment is required to establish a diagnosis and suitable management.
  - Differential diagnosis includes urinary tract infection and renal calculi.
- Fecal incontinence
  - Accidental injury during reconstruction of the vagina for stenosis can lead to fecal incontinence and necessitate repair.
- Sexual dysfunction
  - A number of factors, including vaginal scarring/stenosis, dysparaunia, anxiety, and other psychological factors, can lead to sexual problems.
- Psychosocial dysfunction
  - Many women with fistula have lived through several major traumatic events that can easily cause emotional and mental scars: difficult labor and delivery, stillbirth, fistula, social stigma, spousal abandonment.
- Amenorrhea
  - In some cases the woman's menses may return 2–4 months after surgical repair.
  - Some women continue to have amenorrhea even after repair, and often it is associated with infertility.

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Participant Handout 6-J

Discharge Information Sheet

How to Take Care of Yourself

- Resume normal activities only when you feel comfortable enough to do so.
- Ensure careful genital hygiene.
- Take any medications you have been given correctly and completely.
- Keep your follow-up appointment on _____. Return at any time if you have concerns.
- Make sure you are getting a balanced diet, that you are getting enough to eat, and that you are drinking adequate amounts of water.
- If you are interested in using a family planning method, talk to a provider about starting one well in advance of becoming sexually active again. It is possible to become pregnant as soon as you resume sexual relations.
- If you become pregnant again, make sure you seek antenatal care as soon as you know you are pregnant. Arrange to deliver your baby in a hospital by a planned (elective) cesarean operation. Another vaginal birth could damage the surgical repair and reopen the fistula.
- Contact groups in your community that work with women who have fistulas; they can help you find ways to generate income, and they might offer educational opportunities.
- Seek out other women who have had fistula surgery for support and for help in beginning your life again.

Activities to Avoid

- Lifting heavy objects, until healing is complete
- Having penetrative sexual intercourse, for at least three months after surgery
- Putting anything in your vagina, for at least three months after surgery
- Becoming constipated

Normal Symptoms

- *Lack of periods soon after birth:* If you have not had your period since you gave birth, your period may return in 2–4 months after the surgical repair. In some cases, you may not get your period again.
- *Mild leaking:* Some urine leaking will occur as a result of activities that cause stress, such as coughing or sneezing.
- *Mild pain:* Some mild genital pain may occur in the area of the surgical scar.

Abnormal Symptoms

- Urine or stool leaking continuously
- Fever
- Vaginal discharge that smells bad
- Pain with urination, with or without fever; chills; the need to urinate more frequently or more urgently than usual
- Dizziness, lightheadedness, or fainting
- Severe genital pain
- Nausea or vomiting
- Bleeding that is twice as heavy as a normal period
- Feeling very sad and/or feeling that you cannot care for yourself

Return *immediately* if you experience any of these symptoms!

Special Instructions:

_____

_____

_____

Participant Handout 6-K

Counseling Clients with Special Needs

This handout outlines sample client groups and their corresponding needs. It does not attempt to cover all types of clients with special needs or all of the needs of the client types addressed.

Younger Women

Younger clients tend to be less mature socially; they may be shy and not fully able to express themselves. Therefore, the counselor must make an extra effort to build rapport with younger clients and to use simpler language than is normally used for older clients. Younger women are also more likely to experience unwanted pregnancies than are older women, because they are more often subjected to forced early marriage. The emotional trauma sometimes associated with a forced marriage, coupled with the struggle of dealing with fistula, sometimes makes a young client especially uncommunicative. Delaying pregnancy might not be a priority for her, making her reproductive health counseling needs different from those of an older woman.

Pregnant women who are young and unmarried sometimes face rejection by their communities because they are pregnant at an age considered too early. Alternatively, the community might think that she "deserved" a fistula, as "punishment." Younger clients might have been suspended from school as a result of their pregnancy and might also have lost career opportunities, increasing their shame and amplifying the dread of discussing their situation with anyone.

Older Women

In contrast to some younger women, older clients might already have other children. Therefore, they might not want more children and might focus less on their future reproductive capacity. An older client might have lived for several years with a fistula and might have undergone numerous attempts at repair, which can cause severe scarring and render further surgery difficult. In addition, as women age, their tissue may not heal as readily.

Older women sometimes need health education and counseling that is focused more on menopause and the issues surrounding it than on future pregnancies. Referrals to other reproductive health services, such as cancer screening, are also more relevant to this group.

Reintegration into the community may or may not be easier for older women than for younger women. On one hand, age earns increased respect in some countries, which would help to remove barriers to reintegration. On the other hand, age also makes women more visible within their families and communities; as a result, the embarrassment a woman might feel could become more pronounced, making her social reintegration a more complex emotional issue.

HIV-Positive Women

Women who are HIV-positive or who have full-blown AIDS are less likely to heal fully and therefore need information (such as educational information about nutrition) and referrals to support them in maintaining their health.

First, if an HIV-positive woman's fistula has been successfully repaired, she will need information not only about managing her repair and seeking a cesarean section in the case of future deliveries, but also about the possibility of transmitting HIV to her child if she becomes pregnant again. Second, HIV-positive women should be referred for antiretroviral services and to support and treatment organizations for people with HIV. Third, in some clients, HIV may be easy to identify because of opportunistic infections. Counselors and providers should discuss options with such clients and make them aware of the range of services available.

Women with Physical Disabilities

Counseling a client with physical disabilities usually involves more family participation than counseling for clients without such challenges, particularly if the disability is such that the client is not able to care for herself. In addition, if the client has special communication needs, she might need a counselor with specialized communication skills (sign language for a deaf person, for example).

Women Who Are Mentally or Developmentally Challenged

A woman with mental or developmental challenges might need fistula repair under general anesthesia, rather than under local or spinal anesthesia, because she might not be able to cooperate as needed during surgery.

Some women may present with severe and unmanageable depression that may require psychotherapy and/or medications. If depression has caused a woman to stop eating for a period of time before coming to the facility, she will need a host of physical rehabilitation interventions before undergoing surgery.

Finally, caution must be taken in counseling women with mental illness or developmental challenges and those living in distressed situations, especially if permanent contraception is being considered, because they may not be able to make informed and voluntary decisions. Women with severe mental or developmental challenges may require extensive counseling about limiting their future fertility (e.g., through long-term contraception) because they may be incapable of understanding specific messages related to short-term abstinence and self-care during recovery from fistula repair. They might also be easy targets for abuse. If clients are legally able to give informed consent, they must be counseled carefully, in language that they understand. Family participation in counseling might also be necessary and helpful if the client is unable to understand key messages.

Women with Inoperable Fistula

Clients with an inoperable fistula should ideally be counseled on options for urinary diversion (such as ileal conduit) or vaginal reconstruction (if the vagina is nearly closed because of a surplus of fibrous tissue) for a fistula that is unresponsive to other management. Such options may not be available in your setting or desirable in the individual case. Counselors should also share key messages with partners and/or family members, whose lives will undoubtedly be affected by caring for a woman who will live with a fistula for the rest of her life. The family must be sensitized to the importance of their emotional and physical support and care. Finally, issues related to the maintenance of a sexual relationship when a fistula cannot be repaired would require sensitive counseling for the client and her partner (specific issues vary among clients).

Survivors of Gender-Based Violence

Some clients may experience violence at the hands of their partners as a reaction to the fistula. Other clients with a fistula caused by rape or sexual assault may suffer from the additional trauma of the assault and may have trouble communicating. All women experiencing violence might suffer from fear, depression, "feelings of going crazy," etc., which will require additional psychiatric counseling, emotional support, and/or medication. For more information about counseling women with traumatic fistula or women who have experienced gender-based violence, please see: Fistula Care. 2012. *Counseling the traumatic fistula client: A supplement to the obstetric fistula counseling curriculum*. New York: EngenderHealth.

Adapted from: The ACQUIRE Project and EngenderHealth. 2005. *Report of fistula counseling experts' meeting: March 29 & 30, 2005, Kampala, Uganda*. New York.

Session 7
Family Planning Information and Health-Related Counseling

Refer to pages 142 through 146 of the traumatic fistula supplement for alternative Session 7 Overview—Session Objectives, Points to Remember, Training Methods, Materials, and Advance Preparation.

Session Objectives

During this session, the participants will be able to:

- State the information about family planning that all clients must have before they leave the service site
- Explain the importance of clients' informed choice in effective family planning services
- Describe personal and clinical factors that should be considered in family planning counseling for fistula clients
- Explain why some women may not be able to achieve a pregnancy following fistula repair, even if they want to

POINTS TO REMEMBER

- ✓ All women who have had a surgical repair for obstetric fistula should remain **abstinent from penetrative vaginal intercourse for at least three months to avoid damaging the surgical repair** and reopening the fistula.
- ✓ Once a woman has healed completely from surgery, she may resume penetrative sexual activity when it is comfortable for her.
- ✓ Any client of childbearing age should be presumed to be fertile.
- ✓ Any woman who is menstruating may become pregnant at any time. If she has not had her menstrual period for some time, she can get pregnant any time she ovulates, and that may be *before* her next period.
- ✓ An obstetric fistula client deserves and requires careful and empathetic counseling so that she can make an informed choice about her fertility and her family planning needs and method.
- ✓ If the client chooses a contraceptive sterilization procedure in order to prevent future pregnancies, documentation of informed consent is required.

POINTS TO REMEMBER *continued*

- ✓ Some clients may need referral for infertility investigation and management. Understanding how natural family planning methods work may help some couples who hope to achieve a pregnancy but are currently unable to do so.
- ✓ An obstetric fistula client has the right to make her own choice about her fertility goals, and providers have the obligation to respect her choice.
- ✓ The client's confidentiality should always be respected and information shared only at her request and with her permission.
- ✓ There are no *absolute contraindications* to any family planning methods due to obstetric fistula surgery alone, but there are *some precautions* for certain methods, and those need to be carefully discussed with the client and evaluated by the health care provider.
- ✓ Only *condoms* (male and female) and *abstinence* offer protection against sexually transmitted infections, including HIV.
- ✓ All clients should be advised that if they have intercourse without using a family planning method, they can use emergency contraception to prevent pregnancy.
- ✓ Male/partner involvement in counseling should be encouraged where possible, but only if the client has given consent for his involvement.
- ✓ In some instances, involving the partner in counseling will lead to support for the three-month abstinence period, as well as to the partner's use of and support for the client's chosen family planning method.

Training Methods

- Brainstorm
- Large-group work
- Presentation/discussion
- Case study

Materials

- Flipchart paper, easel, markers, and tape
- Overhead projector (optional)
- Participant Handout 7-A: Essential Information about Family Planning for Clients with an Obstetric Fistula (*also use as a transparency*)
- Participant Handout 7-B: Family Planning Methods
- Participant Handout 7-C: Simple Answers to Clients' Questions about Family Planning
- Participant Handout 7-D: Individual Considerations in Family Planning Counseling for Clients with an Obstetric Fistula
- Participant Handout 7-E: Guidelines for Selecting Contraception, by Method
- Copies of *Family Planning: A Global Handbook for Providers* (World Health Organization and Johns Hopkins Bloomberg School of Public Health Center for Communications Programs)

Advance Preparation

1. Before this session, assign the participants readings in *Family Planning: A Global Handbook for Providers*.
2. Prepare a flipchart listing the objectives of this session.
3. Review all handouts and make one copy for each participant. If possible, copy them on different colors of paper (especially Handout 7-E) to help keep them separate.
4. Prepare transparencies or flipcharts of Handouts 7-A and 7-E.
5. Prepare a flipchart like the example shown below for Activity 1 in Part C:

Individual Considerations in Family Planning Counseling for Clients with an Obstetric Fistula

Case-Study Client	Counseling Situation	Considerations
	1. The client does not want to be pregnant soon.	
	2. The client has had amenorrhea and is not sure about her return to fertility.	
	3. The client was abandoned by her husband but has been asked to return to her husband's compound after the surgical repair and is not sure if her husband will allow her to use a family planning method.	
	4. The client wants to become pregnant as soon as the healing period is over.	
	5. The client has a partner who is putting her at risk of contracting sexually transmitted infections.	
	6. The client never wants to be pregnant again.	
	7. The client has been abandoned by her partner and is not sure about her family planning needs.	
	8. The client has had an unsuccessful repair but plans on being sexually active and is not sure about future fertility.	
	9. Other situations	

6. Find out where family planning services are provided locally for each site, including location, hours, methods available, and cost.
7. Find out what level of knowledge participants have regarding common family planning methods.

Session 7 Training Steps

Session Time (total): 2 hours to 2 hours, 15 minutes

Refer to pages 147 through 154 of the traumatic fistula supplement (Supplement 7A), covering Unwanted Pregnancy Counseling and Emergency Contraception, which should be addressed at the start of this session. These pages also include Supplemental Handouts 7-a and 7-b to present and distribute to participants during these activities.

PART A: RATIONALE

Time: 40–55 minutes

Activity 1: Large-Group Discussion *(10 minutes)*

1. Ask the participants to describe the rationale for linking family planning services to services for fistula clients.
2. Note that regardless of our personal feelings about whether women who have undergone a successful or unsuccessful surgical repair should become pregnant again, establishing linkages with family planning services may be the best way to help women avoid an unwanted pregnancy or postpone a pregnancy until they have healed, emotionally and physically, and are ready to be pregnant again, if this is their desire.
3. Ask the participants to describe their role in delivering family planning methods and services to fistula clients.

TRAINING TIP

The role of the provider in regard to family planning services for women who have undergone fistula repair or who are living with fistula varies from country to country and from site to site. In some settings and within some countries, the provider only makes referrals to outside services. In other settings, the provider offers initial counseling for family planning services within the same institution. In some programs, care for obstetric fistula clients and family planning may be totally integrated, with the same staff providing both services.

Regardless of the relationship between services for obstetric fistula clients and family planning service delivery, the provider is a crucial link between obstetric fistula clients and contraceptive services, helping clients to recognize their need for family planning and to overcome misconceptions and fears regarding contraceptive methods. In addition, by helping clients to build confidence and trust in the health care system, providers help to increase the likelihood that obstetric fistula clients will follow through on a family planning referral. *(continued)*

TRAINING TIP *(continued)*

This session addresses basic information about contraception that all obstetric fistula providers need. If family planning services or counseling are provided by staff already working with fistula clients, additional training in family planning may be needed. On the other hand, if participants are already providing family planning services, some of this information may be redundant. Where there is a mixed group, the providers who have experience in providing family planning can serve as a resource during group activities.

Activity 2: Brainstorm/Discussion *(30–45 minutes)*

1. Ask the participants to brainstorm what family planning information fistula clients might need before they leave the service site.
2. Explain that they will need to explore the woman's or the couple's fertility desires, to tailor family planning counseling appropriately. Remind them that for women or couples desiring a pregnancy, the counselor will need to discuss the recommended period for healing before they attempt to conceive and that they may wish to consider the use of fertility awareness methods to help achieve pregnancy when ready.
3. Explain that the following information must be provided to each fistula client who does not want to get pregnant again soon. Distribute Participant Handout 7-A and display the handout as a transparency, reviewing each point:
   - To prevent damage to the surgical repair of the fistula, the client should be sexually abstinent and should avoid putting anything into her vagina for at least three months following the procedure. Sexual abstinence during this period is to protect the surgical repair and should not be considered a method of family planning.
   - If the client has had amenorrhea, her menstrual period may return 2–4 months after successful surgical repair. She could ovulate before her first menstrual period and therefore could become pregnant before her menses return.
   - The fistula client should start using a family planning method before becoming sexually active (i.e., some methods are used either at the time of intercourse or after intercourse).
   - Some women may have secondary infertility after a fistula, but fistula clients should assume that they are fertile until proven otherwise.
   - The fistula client needs to know where and how to get family planning services (either while in the hospital or after discharge).
4. If the participants have limited or no knowledge of family planning methods, distribute Participant Handout 7-B. *(15 minutes)*
   - Using Handout 7-B as a guide, provide a brief overview of family planning methods.

TRAINING TIP

Trainers should have already assessed the participants to make sure that they have a basic and current knowledge of family planning methods. If they do not, create a session to build the participants' capacity to provide accurate family planning information during counseling. Use **Participant Handout 7-B** as a resource. Also, let participants know that additional resources are listed in Appendix D.

If, after the review, the participants indicate that they need more time on and information about family planning methods, stress that this training is meant to focus on how issues such as family planning relate to counseling for obstetric fistula clients, and that this is not meant as a comprehensive family planning training session. Let the participants know that, if they need further information, you will speak with their site supervisor(s) about scheduling a separate training on family planning.

5. If the participants do not know where family planning services are provided in their area, provide that information, including locations, hours, methods available, and cost.
6. Using Handout 7-C: Simple Answers to Clients' Questions about Family Planning as a guide, review typical clients' questions about pregnancy and family planning, reading aloud the questions only. Ask the participants to provide the answers to the clients' questions, and correct any misconceptions, if necessary.

PART B: INFORMED CHOICE

Time: 30 minutes

Activity 1: Large-Group Discussion *(30 minutes)*

1. Briefly review informed choice, informed consent, and the rights of the client from Session 2.
2. Ask one participant to give an example of how this definition applies to services provided for fistula clients at his or her site.
3. Ask the participants to respond to the following questions:
   - If a woman had a Depo-Provera injection or had a contraceptive implant (e.g., Norplant, Jadelle, or Implanon) inserted against her will during treatment for an obstetric fistula, what can she do about it? How might a woman feel about the health care system if this has happened to her?
   - If a woman had a Depo-Provera injection or a contraceptive implant inserted without adequate information, what are some of the possible side effects and complications?
   - What impact could this practice have on women's willingness to seek medical care in the future?

TRAINING TIP

Possible responses to the three questions posed in Activity 1 include the following:

- Providers may believe that they are acting in a client's best interest by providing a Depo-Provera injection or inserting a contraceptive implant without her consent. This is, however, a violation of the client's rights. Moreover, if a woman does not want a contraceptive implant, she can and will have it removed, thereby undoing the measure that the provider has taken to "protect" her from future pregnancy.
- Inadequate information for contraceptive users about method use and possible side effects can have two results: The user might ignore warning signs of complications, which could have a serious impact on her health and/or on the effectiveness of the method; or she might assume that every physical ailment that occurs after she starts to use the contraceptive is somehow related to it, leading to complaints, excessive follow-up visits, and discontinuation of the method. With the contraceptive implant, this confusion could cause the woman to overlook warning signs, mistakenly attributing unrelated conditions to the contraceptive implant, or to have the implant removed unnecessarily.
- Although coercive practices might prevent unwanted pregnancies among the individual women subjected to them, other women who hear about these practices might be reluctant to seek medical or family planning care, resulting in an increase in morbidity and/or mortality.

4. Summarize: While it is important to make family planning available to and accessible for fistula clients, women should not be required or pressured to choose a contraceptive method.

5. List the points below as reasons why family planning should not be required of all fistula clients, and give examples of the potential negative impact that coerced contraceptive acceptance can have on women and communities.
    - With contraceptive methods that depend on the user (e.g., taking a pill every day, returning to a clinic every three months for an injection, or using a condom) the contraceptive method's effectiveness is generally related to users having enough information to use the method effectively and to their feeling good about continuing its use or about how to switching to another method if they are not satisfied with their first choice.
    - When a contraceptive method is provided through coercion, it might prove to be less effective because the user has not received adequate information about how to use the method properly or resents being forced to accept it. Such circumstances can lead to discontinuation.
    - Discontinuation can result in unplanned pregnancies and further morbidity and mortality.
    - As a result of such coercive practices, the health care system might develop a reputation for being abusive to its clients, which could drive people away from seeking needed services.

PART C: INDIVIDUAL CLIENT CIRCUMSTANCES

Time: 1 hour

Activity 1: Small-Group Exercise *(1 hour)*

1. Explain that you will spend the rest of this session discussing personal and medical circumstances that should be considered when talking with fistula clients about family planning.
2. Divide the participants into five groups, assign situations, and ask them to answer assigned questions.
3. Post the flipchart titled "Individual Considerations in Family Planning Counseling for Clients with Fistula." Whenever possible, fill in the name of the case-study client from Session 4 who most closely matches the description in the "Factors" column. (If none of the case studies match the description, make up a name for a new client to fill in on the flipchart.) Ask: "How would you approach family planning counseling for this client? What would you discuss, and why?"
4. Ask the groups to write their responses in the "Considerations" column for each factor.
5. Reconvene group and share group work with discussion.
6. After all groups have presented, distribute Participant Handout 7-D and discuss any points that were not mentioned during the activity (see Training Tip). Then summarize by noting the importance of considering the individual's personal situation before trying to give information about family planning methods.

TRAINING TIP

If participants overlook key points during this discussion, you can refer to **Participant Handout 7-D** to guide the discussion. However, to help the participants think this through for themselves, do not distribute the handout until *after* the discussion. Then, briefly review each circumstance, noting any differences between the participants' discussion and what is written on the handout.

Reminder: A woman's fertility desires, contraceptive choices, and sense of empowerment in making contraceptive choices involve the sexuality and gender issues that were identified in Session 4 (Parts D and E). Work with the participants to fill in the columns in the handout for this important point.

Activity 2: Discussion *(30 minutes)*

(Note: Alternatively, create an exercise for participants to use content from Handouts 7-C and 7-E or refer to using this content during the role play for counseling case studies)

1. Emphasize that although there are no absolute contraindications to any methods due to fistula surgery alone, some precautions must be taken with certain methods. Review the precautions outlined in Participant Handout 7-C. *(10 minutes)*

2. Distribute Participant Handout 7-E and explain that this handout is useful as a counseling reference because clients often have a particular method in mind when they ask about family planning. Tell the participants that they can look over the handout on their own and can use it to prepare for their counseling role plays later in the workshop. *(10 minutes)*

3. Summarize by reminding the participants that all of these factors—the family planning service-delivery structure at their sites, informed choice, the individual client's situation and clinical condition, and characteristics of the contraceptive methods—should be considered for their individual case-study clients (from Session 4) when they practice counseling in the role plays later in the workshop. Some clients might want or need family planning information before treatment or after, and some might not be interested at all. One of the provider's tasks is to determine the best time to give this information and to ensure that at least the five key points are covered with every client. *(10 minutes)*.

TRAINING TIP

Trainers might find it difficult to complete this discussion in 30 minutes. Participants with a medical background might be curious and might have many questions about specific clinical conditions and the family planning precautions and recommendations related to those conditions. Remind the participants that the purpose of this workshop is to enable providers to give basic information and answer clients' questions and to ensure that clients will follow up as necessary to get family planning and other reproductive health services. This discussion is meant to familiarize providers with clinical conditions that a family planning provider would need to take into consideration when treating obstetric fistula clients and which methods would be suitable. If the participants will be providing family planning services onsite, they will need more in-depth training to cover both the clinical and counseling aspects.

Refer to pages 155 through 167 of the traumatic fistula supplement (Supplement 7B), covering Sexually Transmitted Infections and HIV Postexposure Prophylaxis, which should be addressed at this point in the session. These pages also include Supplemental Handouts 7-f, 7-g, and 7-h, to present and distribute to participants during these activities.

Session 7
Handouts

Participant Handout 7-A

Essential Information about Family Planning for Clients with an Obstetric Fistula

1. The client should be sexually abstinent and should avoid putting anything into her vagina for at least three months after the surgical repair procedure, to prevent damage to the surgical repair of the fistula.
2. If the client had amenorrhea before the surgery, she might ovulate before her first menstrual period after a successful surgery, and therefore could become pregnant before her menses return.
3. The client either should start using a family planning method, such as oral contraceptives or an implant, immediately or should make sure she has an adequate supply of barrier methods (e.g., male or female condoms) before becoming sexually active (which should not be before three months post repair).
4. Some women may have secondary infertility after the fistula is repaired. A woman should assume that she is fertile until this is proven otherwise.
5. The client should know where and how to get family planning services (either while in the hospital or after discharge).

Participant Handout 7-B

Family Planning Methods

Note: *This table describes the most common family planning methods and includes instructions regarding the route and method of administration, effectiveness, side effects, and contraindications.*

Method	Description	Effectiveness		Possible Side Effects	Should weigh potential benefits and risks before use if client . . .
		Typical Use	Perfect Use		
Oral Contraceptives (may be combined pill or progestin-only pill)	• Daily pills containing hormones that mainly work by stopping ovulation • Can be started within five days of start of menstrual cycle or whenever client is reasonably sure she is not pregnant • Woman can become pregnant soon after not taking the pills	About 90% for both types	About 98% for both types	• Nausea • Spotting or bleeding between periods • Mild headaches • Tender breasts • Dizziness • Slight weight gain or loss	• Smokes cigarettes AND is over age 35 or has high blood pressure (especially for combined pill) • Gave birth within the last three weeks • Has been breastfeeding for six months or less • Might be pregnant
Intrauterine Device (IUD) (mostly Copper T)	• Device implanted in uterus that mainly works by stopping the sperm and egg from meeting (by changing uterine lining) • Can be started within seven days of start of menstrual cycle or whenever client is reasonably sure she is not pregnant • Can last up to 12 years • Woman can become pregnant soon after taking it out	99.2%	99.4%	• Longer and heavier periods in the first few months • Bleeding or spotting between periods • More cramps or pain in first three months	• Might be pregnant • Has given birth within previous two days to four weeks • Has had unusual vaginal bleeding recently • Has had an infection or problem in female organs • Is personally at high risk for sexually transmitted infections (STIs)
Injectables (Depot medroxyprogesterone acetate [DMPA] and norethisterone enanthate [NET-EN])	• An injection every 2–3 months that mainly works by stopping ovulation • Can be started within seven days of start of menstrual cycle or whenever client is reasonably sure she is not pregnant	97%	99.95%	• Changes to monthly bleeding • Weight gain	• Has very high blood pressure • Has been breastfeeding for six weeks or less • Might be pregnant • Has some other serious health condition • Has added risk of bone mass loss

Family Planning Methods *(continued)*

Method	Description	Effectiveness		Possible Side Effects	Should weigh potential benefits and risks before use if client . . .
		Typical Use	Perfect Use		
Progestin-Only Implants (e.g., Norplant, Jadelle, Implanon)	• 1–6 plastic capsules placed under the skin of the arm • Work mainly by stopping ovulation • Last three, five, or seven years • Can be started within seven days of start of menstrual cycle or whenever client is reasonably sure she is not pregnant • Woman can get pregnant soon after taking capsules out	99.95%	99.95%	• Light, irregular spotting • No monthly bleeding	• Is breastfeeding six weeks or less • Might be pregnant
Vasectomy	• Tubes that carry semen are cut. • Simple surgical procedure • Permanent method (cannot be reversed easily)	99.85%	99.9%	• Uncommon: complications from procedure, bleeding, or infection • Uncommon: pain in scrotum that lasts months or years	• Has any problems with genitals, such as infection, swelling, injuries, or lumps in penis or scrotum • Has any other serious conditions or infection
Female Sterilization	• Fallopian tubes that carry egg to uterus are blocked or sealed • Permanent method (cannot be reversed easily)	99.95%	99.95%	• Uncommon: complications from surgery, infection, bleeding, injury to organs • Rarely: allergic reactions to or complications due to anesthesia	• Gave birth in previous 1–6 weeks • Might be pregnant • Has infection or other problem in female organs
Male Condom	• A sheath that covers the penis during sex; usually made of latex	85%	98%		• Has a serious allergy to latex
Female Condom	• Loose polyurethane sheath that is usually inserted into the vagina before sex	79%	95%		

Family Planning Methods *(continued)*

Method	Description	Effectiveness		Possible Side Effects	Should weigh potential benefits and risks before use if client . . .
		Typical Use	Perfect Use		
Diaphragm	• A soft, flexible piece of rubber that covers the cervix to block the sperm from entering the uterus • Should be left in for at least six hours after sex but no more than 24 hours after	84%	94%	• Irritation • Burning • Bladder infection	• Recently had a baby or abortion • Is allergic to latex • Ever had toxic shock syndrome
Spermicides	• Gels, creams, foaming tablets, suppositories, foam, or melting film that kills sperm • Should not wash vagina for at least six hours after sex	71%	82%	• Irritation • Burning • Bladder infection	• Has a medical condition that makes pregnancy dangerous • Has high risk for STIs • Is HIV-positive
Lactational Amenorrhea Method (LAM)	• Works by taking advantage of natural period of lack of ovulation after delivery • Most effectively used if all three of the following are true: 1. Baby is less than 6 months old 2. Exclusive or almost exclusive breastfeeding baby breastfed on demand 3. Menstrual periods have not returned	Moderate	Highly effective		• Is having periods • Stops feeding her baby only breast milk • Baby is 6 months old
Fertility Awareness–Based Methods and Standard Days Method	• Learning the days of the month when a woman is fertile and refraining from sexual intercourse or using a barrier method during that time	Moderate	91–99%		• Has an irregular menstrual cycle • Has not had a period since childbirth • Recently stopped using long-lasting injectable

Adapted from: World Health Organization (WHO). 2005. Decision-making tool for family planning clients and providers. Retrieved from http://www.who.int/reproductive-health/family_planning/tool.html; and WHO. 2004. *Selected practices, recommendations for contraceptive use*. 2nd edition. Retrieved from http://www.who.int/reproductive-health/publications/spr/index.htm.

Note: Make *Family planning: A global handbook for providers* available to participants, if this was not already done

Participant Handout 7-C

Simple Answers to Clients' Questions about Family Planning

Q: When can I resume sexual activity?

A: You need to abstain from penetrative vaginal intercourse for at least three months after surgical repair. Having penetrative intercourse sooner than this might damage the surgical repair and reopen the fistula. After you have healed completely from the surgery, you may resume penetrative sexual activity when it is comfortable for you. (*Note:* This should be explained to the woman's partner, if possible. Once resumed, intercourse should be gentle and with consideration for the woman. See: WHO. 2006. *Obstetric fistula: Guiding principles for clinical management and programme development*. Geneva, p. 54.)

Q: How soon can I become pregnant?

A: If you are menstruating, you can become pregnant at any time. If you have not had your menstrual period for some time, your period might return over the next two months. You can get pregnant any time you ovulate, and that could be before your next period. However, for any future pregnancy after repair, as soon as you realize that you are pregnant, you should report to the nearest antenatal care clinic and attend all antenatal visits, as advised. Be sure to ask your provider what you should know about "birth preparedness," the need for all of your future babies to be delivered through cesarean section to avoid repeat fistula, and the nearest facility where you should report for cesarean delivery. (*Note:* Be sure to explain that due to a variety of medical problems related to fistula [see Participant Handout 3-C], some women face a high rate of secondary infertility. This may pose significant emotional and psychological problems, considering the importance many societies place on childbearing.)

Q: How can I avoid becoming pregnant again?

A: If you do not want to become pregnant, you should start using a family planning method before becoming sexually active (i.e., having sexual intercourse).

Q: Which methods can I use?

A: There are no *absolute contraindications* to any methods **due to your surgery alone**, but there may be *some precautions* you should take:

- Some methods have a higher risk of failure and therefore might not be appropriate for you. These include barrier methods, withdrawal (coitus interruptus), and some fertility awareness methods.
- Fertility awareness might not be appropriate for you if you have not yet had a menstrual period.

- The diaphragm might not be appropriate for you if you have an anatomical deformity resulting from the fistula or the surgery or if there is associated scarring of your genital tract.
- Spermicides might not be appropriate for you if you have constant discharge (e.g., before repair or after failed repair).
- An intrauterine device (IUD) might not be appropriate for you if you have some special risks related to the type of fistula you had. For some clients, a vesicocervical fistula or its repair can damage the cervix so much that it might not hold an IUD. Also, if you have severe scarring of the genital tract (as sometimes happens after female genital cutting), insertion of an IUD could be difficult.
- Combined oral contraceptives (containing estrogen and a progestin) might not be appropriate for you if you are going to be on prolonged bed rest, because they might increase your risk of experiencing a blood clot or other complications associated with estrogen.
- The decision to use a permanent method of family planning might be best made after you have healed and successfully begun your life after surgical repair and have had time to recover from all the emotional turmoil from your difficult pregnancy and labor, the fistula, and social changes resulting from your fistula.

Ask your family planning counselor to discuss which methods may be right for you.

Q: Which methods protect against HIV and other sexually transmitted infections?

A: Only *condoms* (male and female) and *abstinence* offer protection against HIV and other sexually transmitted infections. Diaphragms offer limited protection against sexually transmitted infections and HIV.

Note: If you have intercourse without using a family planning method, ask your provider about emergency contraception. If you take a special dose of oral contraceptives within five days after unprotected intercourse, you have a much lower chance of becoming pregnant. Also, if you have no contraindications to the IUD, one inserted within five days after unprotected intercourse can serve as an emergency contraceptive. If the time of ovulation can be estimated, the IUD can be inserted more than five days after intercourse, if necessary, as long as the insertion does not occur more than five days after ovulation.

Adapted from: EngenderHealth. 2003. *Counseling the postabortion client: A training curriculum*. New York.

Participant Handout 7-D

Individual Considerations in Family Planning Counseling for Clients with an Obstetric Fistula

For all scenarios, the following recommendations should be followed:

- If the woman wishes, providers should include her partner in counseling. In some instances, involving the partner in counseling will lead to his use of and support for contraception. However, if the woman, for whatever reasons, does not want to involve her partner, her wishes should be respected.
- Protect the confidentiality of the woman's information (even if she does not involve her partner). Confidentiality should always be respected and information should be shared only at the woman's request and with her permission.
- Do not force the woman to accept a family planning method, but make sure that she understands that early intercourse can disrupt the repair site and undo all that has been done.

Client's Situation	Recommendations	Rationale
1. The client does not want to become pregnant soon.	• Consider all temporary methods.	The woman would like to become pregnant in the future, so permanent methods are not appropriate.
2. The client has had amenorrhea and is not sure about her return to fertility.	• Consider all temporary methods. • Provide information or a referral if the woman needs other reproductive health services. • Provide information on how the amenorrhea of fistula may interact with the amenorrhea of Depo-Provera or other progestin-only methods such as contraceptive implants.	The woman might need further gynecological consultations to deal with prolonged amenorrhea.
3. The client was abandoned by her husband but has been asked to return to her husband's home/compound after the surgical repair and is not sure if her husband will allow her to use a family planning method.	• Discuss methods that the woman can use without her partner's knowledge (e.g., injectables). • Inform her about emergency contraception if she does not accept a family planning method. • Do not recommend methods that the woman will not be able to use effectively.	Information about emergency contraception is important because the woman might be at risk for unprotected intercourse if she does not feel empowered to begin a family planning method.

(continued on next page)

Client's Situation	Recommendations	Rationale
4. The client wants to become pregnant as soon as the healing period is over.	• Reiterate the importance of the three-month abstinence period to prevent damage to the surgical repair. • Consider all temporary methods. • Provide information or a referral if the woman needs other reproductive health services.	The woman has the right to make informed choices about her fertility.
5. The client has a partner who is a high potential risk for transmission of HIV or other sexually transmitted infections.	• Discuss dual protection and negotiation of condom use. • Consider all temporary methods. • Inform her about emergency contraception (or other contraception, if appropriate). • Do not recommend methods that the woman will not be able to use effectively.	Information about dual protection is important because the woman needs protection from both pregnancy and sexually transmitted infections.
6. The client never wants to be pregnant again.	• Discuss permanent methods and encourage the woman (and her partner) to explore their fertility goals. • Consider all temporary methods, including long-acting, nonpermanent ones. • Provide a referral for continued contraceptive care.	Depending on the woman's situation, she might find it difficult to make a free, informed decision either before or right after the surgical repair.
7. The client has been abandoned by her partner and is not sure about her family planning needs.	• Provide information on contraceptive choices, availability, and timing of use. • Discuss dual protection and negotiation of condom use. • Inform her about emergency contraception (or other contraception, if appropriate).	Although she does not need contraception at this time, she needs information in case she chooses to become sexually active again. The woman might be at risk of unprotected intercourse and might need emergency contraception.
8. The client has had an unsuccessful repair but plans on being sexually active and is not sure about her desire for future fertility.	• Consider all temporary methods for which there are no contraindications. Do not encourage the use of permanent methods at this time. • Provide a referral for continued contraceptive care. • Provide information or a referral if the woman needs other reproductive health services.	There might be more surgery in her future, and the outcomes of future surgical repair attempts might affect her fertility goals.
9. The client wanted to become pregnant after the repair but was unable to.	• Provide information on natural family planning, as an understanding of how these methods work may help some couples who desire a pregnancy to identify their fertile days. • Refer the woman and her partner for infertility investigation and management (if such services are available).	Fistula patients may experience a high rate of secondary infertility, as the result of a combination of amenorrhea, pelvic inflammatory disease, and damage or scarring of the genital tract.

Adapted from: EngenderHealth. 2003. *Counseling the postabortion client: A training curriculum*. New York.

Participant Handout 7-E

Guidelines for Selecting Contraception, by Method

Method	Characteristics	Remarks
Fertility awareness–based methods	• Have no cost* • Produce no change in sexual function • Have no long-term side effects *The standard days method may be available in some countries; with this method, there is a minimal cost for the cycle beads.	• Are difficult to use if the woman has amenorrhea following obstetric fistula • May be difficult to use early on in the healing process after surgical repair because of the possibility of increased vaginal discharge (for the cervical mucus method) • Require the woman and her partner to be motivated and have a thorough understanding of how to use the method • Require extensive instruction and counseling • Require condom use if client is at risk of sexually transmitted infections (STIs), including HIV • Have relatively high failure rates if sex is unprotected before ovulation • May be difficult to use with some methods if cycles have not returned or if the woman is having unusual vaginal discharge (for the cervical mucus method) or fevers (for the basal body-temperature method)
Nonfitted barrier methods (latex and vinyl male/female condoms; vaginal sponge and suppositories [foaming tablets, jelly, or film])	• Are inexpensive • Are good interim method if use of another method must be postponed • Require no medical supervision • In the case of condoms (latex and vinyl), provide protection against STIs, including HIV • Are easily discontinued • Are effective immediately	• In the case of spermicides, might not be appropriate if the woman has constant discharge (e.g., before repair or after failed repair) • Are less effective than intrauterine device (IUD) or hormonal methods • Require use with each episode of intercourse • Require continued motivation • Require resupply • May interfere with intercourse
Fitted barriers used with spermicides (diaphragm or cervical cap with foam or jelly)	• Are relatively inexpensive • Require no medical supervision for use • May provide some protection against STIs, including HIV • Are easily discontinued • Are effective immediately	• In the case of the diaphragm, might not be appropriate if there has been an anatomical deformity from the fistula or surgery or if there is associated scarring of the genital tract • Are less effective than IUD or hormonal methods • Might not be appropriate following fistula repair • In some cases, require use with each episode of intercourse • Require continued motivation • Require resupply • Are associated with urinary tract infections (diaphragm) (Note: Obstetric fistula clients are already at increased risk of urinary tract infections.) • Require fitting by trained service provider (diaphragm, cervical cap)

Guidelines for Selecting Contraception, by Method *(continued)*

Method	Characteristics	Remarks
Oral contraceptives (OCs) (combined and progestin-only) (Note: Little is known about the use of the contraceptive patch and "Seasonale," which allows quarterly menses, because these are not yet widely available to women with fistulas. But many of the considerations would likely be similar to those noted here for OCs.)	• Are highly effective • Can be started immediately, even if infection is present • Can be provided by nonphysicians • Do not interfere with intercourse	• Require continued motivation and daily use • Require resupply • Require condom use if client is at risk of HIV and/or other STIs • Might have reduced effectiveness with long-term use of certain medications (e.g., rifampin, dilantin, or griseofulvin) • In the case of combined oral contraceptives (any method that contains estrogen), might not be appropriate if the woman is going to be on prolonged bed rest
Injectables (Depot medroxyprogesterone acetate [DMPA] and norethisterone enanthate [NET-EN])	• Are highly effective • Can be started immediately, even if infection is present • Can be provided by nonphysicians • Do not interfere with intercourse • Do not depend on user's actions for effectiveness (except for injection every 2–3 months) • Do not require client to obtain supplies	• May cause irregular bleeding; may cause amenorrhea after 9–12 months of use (DMPA); excessive bleeding may occur in rare instances • May cause delayed return to fertility • Require injections every two (NET-EN) or three months (DMPA) • Require condom use if client is at risk for HIV and/or other STIs
Progestin-only implants (Norplant, Jadelle, Implanon) (Note: Little is known about the use of the hormonal vaginal ring in women with fistulas. Considerations may be similar to those of barrier methods and changes in hormone absorption.)	• Are highly effective • Provide long-acting contraceptive protection (effective for three, five, or seven years) • Allow immediate return to fertility upon removal • Do not interfere with intercourse • Do not require client to continually obtain supplies	• May cause irregular bleeding (especially spotting) or amenorrhea • Require a trained provider to insert and remove • Are cost-effective only with long-term use • Require condom use if client is at risk for HIV and/or other STIs

Guidelines for Selecting Contraception, by Method *(continued)*

Method	Characteristics	Remarks
Copper IUD (*Note:* Little is known about the use of the progestin-bearing IUD, Mirena, in women with fistulas, but the considerations may be similar to those of the Cu IUD and those of progestin-only contraception [e.g., irregular bleeding]).	• Is highly effective • Provides long-acting contraceptive protection • Allows immediate return to fertility upon removal • Does not usually interfere with intercourse • Does not require client to continually obtain supplies • If the woman wants, she can check her IUD strings from time to time, especially in the first few months and after monthly bleeding • Requires only one follow-up visit, unless there are problems	• May increase menstrual bleeding and cramping during the first few months • Necessitates condom use if client is at risk for HIV and/or other STIs • Requires a trained provider to insert and remove • Can result in uterine perforation during insertion (risk is increased if the woman has had a vesico-uterine fistula) • May increase risk of pelvic inflammatory disease and subsequent infertility for women who have chlamydia or gonorrhea infection at the time of insertion
Female Sterilization (Little is known about the use of Essure or transcavitary tubal occlusion in women with fistulas, but the considerations might be similar.)	• Is a permanent method • Is among the most effective female methods • Requires no further action once completed • Does not interfere with intercourse • Produces no change in sexual functioning • Has few long-term side effects • Is immediately effective	• Requires adequate counseling and fully informed consent before being performed, which often is not possible early on in the healing period after obstetric fistula repair or if the repair has not been successful • Has slight possibility of surgical complications • Requires staff trained in female sterilization and appropriate equipment • Requires condom use if client is at risk for HIV and/or other STIs
Vasectomy	• Is a permanent method • Is the most effective male method • Does not interfere with intercourse • Produces no change in sexual functioning • Causes no serious long-term side effects	• Requires adequate counseling and fully informed consent before being performed • Has slight possibility of complications, as with any minor surgical procedure • Is not effective until after 12 weeks following the procedure • Requires vasectomy-trained staff and appropriate equipment • Requires condom use if client is at risk for HIV and/or other STIs

Adapted from: EngenderHealth. 2003. *Counseling the postabortion client: A training curriculum.* New York.

Session 8
Counseling for the Client's Family

Refer to pages 170 through 175 of the traumatic fistula supplement for alternative Session 8 Overview—Session Objectives, Points to Remember, Training Methods, Materials, and Advance Preparation.

Session Objectives

During this session, the participants will:

- Describe the purpose of counseling for family members of fistula clients during each stage of service delivery
- List family members who can benefit from counseling
- Differentiate between issues that might be best dealt with in joint counseling (i.e., the client and family members together) and issues that might be best dealt with through individual counseling
- In classroom role plays, demonstrate counseling of family members during each stage of service delivery (as appropriate), using communication skills to address family members' needs

POINTS TO REMEMBER

- ✓ Family members are especially important in the overall success of fistula repair and in the client's successful reintegration into her home and community. However, the decision as to which family members are involved, and at which stages in a client's care, depends on the client's particular situation and her desire for their involvement.
- ✓ Providers must be sensitive to the client's needs and desires with regard to her family's participation in her care, and should only include others (such as her husband or other family members or friends) in counseling sessions if the client chooses to have them present.
- ✓ Providers should respect the client's privacy and confidentiality by providing information about the client's condition and treatment to family members only if the client is present and/or requests that this information be shared with her family.
- ✓ The way in which a family member is asked to support the client depends on the client's needs and the family member's capabilities. To maximize each chosen family member's ability to support the client, providers need to provide timely, targeted counseling for any and all family members who will be assisting in the client's care.

POINTS TO REMEMBER *(continued)*

- ✓ The benefits of providing counseling to couples include the following:
  - They will be more likely to respect recommended period of abstinence following surgical repair.
  - They will make better use of contraceptive methods.
  - They will be more likely to practice joint decision making.
  - Communication between the two will be increased.
- ✓ The benefits of providing joint counseling with family members and clients include the following:
  - Clients will be more likely to return for follow-up visits.
  - Clients will be more likely to seek timely medical, gynecologic, and obstetric care.
  - Clients will experience better health outcomes.
- ✓ The risks of providing couples counseling or joint counseling include the potential to:
  - Expose information that the client does not want to share
  - Inhibit the client's right to informed choice
  - Cause conflict within the couple or family
- ✓ When an obstetric fistula client returns to her community, whether she joins her husband's home or not, she will need social support, material support, and socioeconomic support from her family and community.

Training Methods

- Presentation/discussion
- Brainstorm
- Role play (*Note:* For Parts B–D, follow the general role-play guidelines provided below. The specifics for each session will be outlined under the instructions within the session.)

Materials

- Flipchart paper, easel, markers, and tape
- Flipcharts of the client case studies (from Session 4)
- Participant Handout 8-A: Counseling the Client's Family Members—Stage 1 Scenario
- Participant Handout 8-B: Counseling the Client's Family Members—Stage 2 Scenario
- Participant Handout 8-C: Counseling the Client's Family Members—Stage 3 Scenario
- Participant Handout 8-D: Counseling the Client's Family Members—Stage 4 Scenario
- Participant Handout 8-E: Counseling the Client's Family Members—Stage 5 Scenario
- Participant Handout 8-F: Key Family Members Who Can Support the Client

- Participant Handout 8-G: Social Support for Obstetric Fistula Clients
- Participant Handout 8-H: Counseling the Client's Family Members
- Transparency 8-A: Sample Counseling Learning Guide for the Preoperative and Immediate Postoperative Periods
- Transparency 8-B: Sample Counseling Learning Guide for the Discharge/Follow-Up Periods
- Props for role-plays, such as client-education materials, a blanket, a curtain, drapes, or other materials that can be used to make the role plays more realistic
- Video camera and television or monitor (optional)

Advance Preparation

1. Prepare a flipchart listing the objectives of this session.
2. Review all handouts and make one copy for each participant.
3. Prepare the following flipcharts:
   - "Opportunities for Counseling Family Members: Admission to the Ward and Preoperative Period"
   - "Opportunities for Counseling Family Members: Postoperative Period"
   - "Opportunities for Counseling Family Members: Discharge and Follow-Up"
   - A flipchart with two columns: "Benefits of Providing Joint Counseling" and "Risks of Providing Joint Counseling"
   - "Family Members' Needs and Concerns: Admission and Preoperative Period"
   - "Family Members' Needs and Concerns: Postoperative Period"
   - "Family Members' Needs and Concerns: Discharge and Follow-Up"
   - "Family Members' Reactions to Client with Fistula: Admission and Preoperative Period"
   - "Family Members' Reactions to Client with Fistula: Postoperative Period"
   - "Family Members' Reactions to Client with Fistula: Discharge and Follow-Up"
4. Prepare the room so that each group can sit near their respective case-study and feelings flipcharts.
5. Set up the video camera and television or monitor (optional).

TRAINER'S NOTE

General Role-Play Guide

Parts B through D in Session 8 all follow the same format. The following is a general role-play guide that can be used for all counseling practice in this session, following the four activities described in detail here.

During the role plays, the participants will use the case-study clients (from Session 3) as characters. Although the process is the same for each role play, the transparencies, handouts, and communication tasks will differ.

(continued)

TRAINER'S NOTE *(continued)*

Activity 1: Brainstorm/Discussion

1. Ask the participants this question: What is the purpose of counseling family members? Who would be considered key family members? What information do family members need to support the fistula client during the assigned stage (e.g., informational needs regarding the cause of the fistula, clinical and social aspects of the condition, and clinical and social of the fistula; effects on the client and on the family member; and what family members can do to help)? What other needs and concerns might family members have?
2. Write the participants' comments on the prepared flipchart entitled "Family Members' Needs and Concerns: [assigned stage]."
3. Ask participants to brainstorm the range of emotions that a family member might feel. Write the participants' comments on the prepared flipchart entitled "Family Members Reactions to Client with Fistula: [assigned stage]," and post the flipchart on the wall.
4. Ask the participants how the service provider can address these needs, both verbally and nonverbally. Summarize by explaining the importance of offering family members reassurance and attention.
5. Summarize by reviewing the counseling guidelines for the assigned stage.

Activity 2: Role-Play Preparation

1. Project Transparencies 8-A and 8-B from Appendix D to provide a guide for counseling.
2. Distribute Handouts 8-F: Key Family Members Who Can Support the Client 8-G: Social Support for Obstetric Fistula Clients, and 8-H: Counseling the Client's Family Members for the participants to use as a reference when developing messages to provide to the client or the client's family member. These are just guides, and the participants should compare them with protocols from their respective institutions.
3. Divide the participants into the same case-study client groups formed in Session 4, Part A, Activity 4 (page 95). Seat each group near where its case-study and feelings flipcharts are posted on the wall. Assign the setting or service-delivery stage for the role play.
4. Ask each group to do the following:
   - Develop a five- to 10-minute role play for counseling during the assigned stage that accomplishes the following communication tasks:
     a. Assesses the most appropriate family member to include in counseling
     b. Assesses the family member's readiness to discuss his or her concerns and feelings
     c. Encourages the family member to ask questions and to express his or her opinions and feelings
     d. Answers the family member's questions with simple explanations *(continued)*

TRAINER'S NOTE *(continued)*

Activity 2: Role-Play Preparation *(continued)*

- Remember to use the open-ended or feeling questions that the participants developed to address the sexuality and gender concerns.

TRAINER'S TIP

Remember that the trainer may have to model/demonstrate a segment of the role play or show examples of reflecting (interpreting the feelings behind a client's words).

5. Distribute props to each group.
6. Use Transparencies 8-A and 8-B in Appendix D, as well as Participant Handout 8-H, to observe those participating in the role play, to ensure that they are following the counseling standards.
7. Walk around the room and offer help as the participants develop their role plays.

Activity 3: Role-Play Practice

1. Randomly select one group to conduct its role play for the other participants to observe, using the counseling checklist as an observer's guide for giving feedback.
2. Introduce the role play by reminding the participants of the circumstances of the case study.
3. Videotape the role play (optional).
4. Stop the role play if it exceeds the time limit.
5. Play the videotape of the role play (if video is used) and discuss for 10 minutes, asking the following questions:
   - How do you think the "client" or "family member" felt during this role play?
   - Which communication tasks were achieved?
   - Was the information provided technically accurate and appropriate?
   - Was simple language used to explain technical issues?
   - What did the group do well? Start by asking the group to evaluate themselves; then ask other participants for their feedback; finish by providing a summary of positive feedback.
   - How could they improve (both the technique and the content)? Again, start by asking the group to evaluate themselves, then ask other participants for their feedback, and finish by providing a summary of how to improve.
6. Summarize the feedback and add any points that were not covered by the participants.

(continued)

TRAINER'S NOTE *(continued)*

Activity 4: Discussion

1. Summarize the role plays by asking the following questions:
   - What did you learn from this session?
   - How could you apply what you have learned in your own work setting?
2. Be prepared to conduct your own demonstration role play in case key steps or skills need to be reinforced.

Session 8 Training Steps

Session Time (total): 4 hours, 5 minutes, to 4 hours, 20 minutes

Refer to pages 176 through 181 of the traumatic fistula supplement. This includes:

- *Supplement 8A, which covers the Impact of Sexual Violence and Traumatic Fistula on Husbands and Families*
- *Supplement 8B, which provides an alternative/expanded version of Session 8 Part A, Activity 1*

Both of these should be addressed at the start of this session, in place of Activity 1.

PART A: OVERVIEW OF COUNSELING FOR THE CLIENT'S FAMILY

Time: 1 hour, 5 minutes

Activity 1: Large-Group Exercise/Discussion *(25 minutes)*

1. Introduce this activity as an opportunity to draw on the participants' experience with providing care to women with fistula and to identify the needs and opportunities for family members' participation in these services. This activity is also designed to help the participants expand their awareness of ways to engage men and other family members as partners in the client's care.

TRAINING TIP

This activity is designed to help the participants identify opportunities for family members to join obstetric fistula clients during counseling. Emphasize that the goal of the discussion is to identify as many opportunities as possible, not to evaluate whether they would be successful. In some cases, it may be appropriate to counsel family members separately from the client, but with the client's understanding and agreement.

2. Divide the participants into three groups: Admission/Preoperative Period, Postoperative Period, and Discharge and Follow-Up. Distribute the flipchart paper and markers to each group. Give each group five minutes to brainstorm opportunities for family members, including partners, to be included in counseling during the period assigned to the group. Ask each group to choose a reporter who will present their ideas to the larger group.
3. After five minutes, reconvene the group and ask the reporters to present their findings. Encourage the other participants to share any additional thoughts or to ask clarifying questions if they do not understand something on another group's list. Do not let the participants make editorial comments about the lists (e.g., "That would never work" or "That is not appropriate").
4. Allow 15 minutes for the reporters to complete their presentations.

Activity 2: Discussion *(40 minutes)*

1. Ask the participants to identify some of the benefits of providing joint counseling (i.e., couples counseling or counseling clients and family members together). Allow them to share their thoughts, and record their responses in the "Benefits of Providing Joint Counseling" column on the prepared flipchart.

2. Mention any important benefits that the group did not discuss:
   - For couples:
     - They will be more likely to respect recommended period of abstinence following surgical repair.
     - They will make better use of contraceptive methods.
     - They will be more likely to practice joint decision making.
     - Communication between the two will be increased.
   - For joint counseling with family members and clients:
     - Clients will be more likely to return for follow-up visits.
     - Clients will be more likely to seek timely medical, gynecologic, and obstetrical care.
     - Clients will experience better health outcomes.

3. Ask the participants to identify some of the risks of providing joint counseling. Allow them to share their thoughts, and record their responses in the "Risks of Providing Joint Counseling" column on the prepared flipchart.

4. Mention the following important risks if the group does not identify them:
   - The potential to expose information that the client does not want to share
   - The potential to inhibit the client's right to informed choice
   - The potential to cause conflict

5. Divide the participants into five groups. Distribute Participant Handouts 8-A through 8-E, giving the participants in each group copies of the handout with the corresponding number. For example, distribute a copy of Participant Handout 8-A (on Counseling the Client's Family Members—Case-Study Group 1) to each of the participants in Group 1. Ask each group to read the scenario and then think of a strategy, a possible response, and a gender consideration (if applicable) for their scenario. Ask each group to choose a reporter to summarize the scenario and present their findings to the large group. Allow each group 10 minutes to discuss their answers.

6. Reconvene the group and ask each group's reporter to summarize the scenario and present their findings to the larger group. Encourage other participants to share additional thoughts. Allow 20 minutes for completion.

7. Close the activity by asking the group if they can think of any other scenarios that might occur when providing joint counseling. If so, discuss these scenarios with the group.

PART B: COUNSELING DURING ADMISSION AND THE PREOPERATIVE PERIOD

Time: 1 hour to 1 hour, 5 minutes

Note: For Part B, participants will role-play counseling in the admission and preoperative period. Participants should refer to Transparency 8-A and should follow the General Role-Play Guide to prepare, present, and discuss the role plays. Thus, this stage of the training will consist of four activities:

- Activity 1: Brainstorm/Discussion (15 minutes)
- Activity 2: Role-Play Preparation (15 minutes)
- Activity 3: Role-Play Practice (20 to 25 minutes)
- Activity 4: Discussion (10 minutes)

TRAINING TIP

Remind the participants that some family members might take an active part in client care, including taking responsibility for food, hygiene, and basic physiotherapy. Others might have to look after matters back home, such as children and farm animals or other concerns. The family members might have informational, emotional, material, or other needs that need to be addressed.

PART C: COUNSELING AFTER SURGERY

Time: 1 hour to 1 hour, 5 minutes

Note: For Part C, participants will role-play counseling in the period immediately following surgery to repair the fistula. Participants should refer to Transparency 8-A and should follow the General Role-Play Guide to prepare, present, and discuss the role plays. Thus, this stage of the training will consist of four activities:

- Activity 1: Brainstorm/Discussion (15 minutes)
- Activity 2: Role-Play Preparation (15 minutes)
- Activity 3: Role-Play Practice (20 to 25 minutes)
- Activity 4: Discussion (10 minutes)

PART D: COUNSELING AT DISCHARGE

Time: 1 hour to 1 hour, 5 minutes

Note: For Part D, participants will role-play counseling at the time of discharge. Participants should refer to Transparency 8-B and should follow the General Role-Play Guide to prepare, present, and discuss the role plays for each stage. Thus, each of the three parts will have four activities:

- Activity 1: Brainstorm/Discussion (15 minutes)
- Activity 2: Role-Play Preparation (15 minutes)
- Activity 3: Role-Play Practice (20 to 25 minutes)
- Activity 4: Discussion (10 minutes)

TRAINING TIP

The discussion activity for counseling at discharge should cover sexuality issues, hygiene, future pregnancies and the need for early birth preparedness, stigma and vocational skills, and possible links to community support groups, if any are available. Special consideration should also be made for women with irreparable fistula.

Refer to page 182 of the traumatic fistula supplement for additional Part D Points to Discuss.

Session 8
Handouts

Participant Handout 8-A

Counseling the Client's Family Members—Case-Study Group 1

Issue: During the counseling session with a couple, the man does all or most of the talking. He interrupts the client (his partner), always speaks first, and speaks on his partner's behalf.

List possible reasons why the partner is responding in this way.

How do you think the fistula client might respond?

What strategy (or strategies) can you use to manage this situation?

To what degree might gender be involved? Explain.

Participant Handout 8-B

Counseling the Client's Family Members—Case-Study Group 2

Issue: During a discussion about the need for sexual abstinence after surgery and the need for careful contraception until the woman's body is completely healed, the client's partner seems uninterested and does not respond to questions (or responds with one-word answers).

List possible reasons why the partner is responding in this way.

How do you think the fistula client might respond?

What strategy (or strategies) can you use to manage this situation?

To what degree might gender be involved? Explain.

Participant Handout 8-C

Counseling the Client's Family Members—Case-Study Group 3

Issue: During a discussion about contraceptive options, the client's mother/caregiver stops the discussion and says it is not necessary to talk about contraception because her daughter will probably never have sex again.

List possible reasons why the mother/caregiver is responding in this way.

How do you think the fistula client might respond?

What strategy (or strategies) can you use to manage this situation?

To what degree might gender be involved? Explain.

Participant Handout 8-D

Counseling the Client's Family Members—Case-Study Group 4

Issue: The obstetric fistula client is very young and her mother/caregiver discounts the young woman's ability to understand instructions and care for herself.

List possible reasons why the mother/caregiver is responding in this way.

How do you think the fistula client might respond?

What strategy (strategies) can you use to manage this situation?

To what degree might gender and age be involved? Explain.

Participant Handout 8-E

Counseling the Client's Family Members—Case-Study Group 5

Issue: The fistula client reveals that during screening procedures it was discovered that she has chlamydia. This information is a surprise to her partner.

List possible reasons why the client chooses to reveal this information while a third party, the counselor, is present.

How do you think the partner might respond to this information?

What strategy (strategies) can you use to manage this situation?

To what degree might gender be involved? Explain.

Participant Handout 8-F

Key Family Members Who Can Support the Client

To help the client's family discover how they can help her, the counselor must ask questions about how the family members think, feel, behave, and interact. The counselor's empathy will encourage the family members to express honest and deeply felt aspects of their experience because they will feel understood and accepted by the counselor. Family members are especially important to the success of the client's surgical repair and to her successful reintegration into her home and community. However, which family members should be involved, and at which stages in a client's care, depends on the client's particular situation and her wish for particular members of her family to be involved.

When helping a fistula client decide whether to include a husband/partner or any family member or friend in counseling sessions with or about the client, providers should keep a few simple guidelines in mind:

- Be sensitive to the client's needs and desires with regard to her family's participation in her care.
- Include family members in counseling **only if** the client desires their presence. Communicate to the client that she has a choice and only needs to agree to her family's participation if she truly desires their presence. Reinforce that the family member(s) need not remain throughout the whole counseling session.
- Respect the client's privacy and confidentiality by providing information about the client's condition and treatment **only if** the client is present and/or requests that this information be shared with family members.
- Assess the family member's ability or capacity to give and/or receive information.
- Assess the family member's ability or capacity to provide support to the client.
- Explore the family member's needs and feelings.

How well a family member will be able to support the client will depend on the client's needs and the family member's capabilities. To maximize family members' ability to support the client, providers need to provide timely, targeted counseling for any and all family members who will be assisting in the client's care.

Partners/husbands might need counseling that addresses the following issues:

- Myths/misconceptions about fistula
- The client's needs for care before, during, and after surgical repair
- How to provide emotional, physical, and material support after treatment
- How to deal with depression and other emotional and physical results of fistula
- The need for sexual abstinence for at least three months after repair and discharge, and ideally the need to avoid pregnancy for six months to one year following the repair, to avoid reopening the fistula.
- The importance of receiving adequate antenatal care from a trained health care professional in

subsequent pregnancies. As soon as she realizes that she is pregnant, the woman should report to the nearest antenatal care clinic and should attend all antenatal visits, as advised. The partner/husband and client should ensure that the antenatal care provider informs her about birth plans/preparedness, the danger signs of pregnancy and delivery, the names of all medications/tablets she is given, and how they help her in pregnancy,

- The need for all her future babies to be delivered through cesarean section, to avoid repeat fistula, and the need to attend the nearest well-equipped facility that can perform cesarean deliveries.
- How to make informed choices about reproductive health with the client, including the need to work with her to prevent a pregnancy until six month to one year, when the repair has healed
- How to help the woman get timely medical, gynecologic, and obstetric care
- Sexuality after either successful or unsuccessful surgery—particularly the need for intercourse to be gentle and performed with consideration for the woman
- How to assist the client in improving/regaining her sense of self and her self-esteem
- How to assist/support the client's reintegration into the community

In some situations, a partner or other support person should be included in the same counseling session as the client—for instance, to dispel myths about why the client developed a fistula in the first place, cover issues related to postoperative care, and emphasize the need to support her reintegration back into the community. In other situations, counseling might be more successful if the client and partner are counseled individually first and then as a couple (with the client's permission and if her partner is still part of her life). Individual counseling might be more appropriate when initially discussing issues around sexuality, sexually transmitted infections, other sexual partners, or emotional support for the client (e.g., helping her improve her self-esteem and regain a sense of self). And additional individual sessions might be helpful after joint counseling.

Parents, children, siblings, and in-laws are other key family members who could benefit from direct counseling, depending on the client's situation and her desire to include them. In some cases, children might play an important role in caring for the woman, especially if they are able to help with household chores such as washing and fetching water or wood while the client recovers. When the client herself is young, it can be important to have a second set of ears in a counseling session to make sure that the client understands information presented by the counselor.

Friends can play a critical role in delivering key messages to clients and family members. **Community leaders** might be able to help ensure that a woman has access to health care services and to support her reintegration into the community. Finally, **employers and teachers** can also play a role in a woman's recovery, particularly in situations where girls or women have the opportunity to return to previous employment or school.

Participant Handout 8-G

Social Support for Obstetric Fistula Clients

Social Support Provided by Family/Community

When a fistula client returns to her community, whether she joins her husband's home or not, she will need:

1. A sense of belonging (to feel loved, to be talked to)
2. Support for reintegration into her family and community (using existing community support structures)
3. To feel comfortable sharing the problem with friends
4. To feel respected and to maintain her dignity
5. Access to community support structures for fistula clients
6. Support and understanding of her condition from her family, friends, and community
7. To stay with loving family members who understand her problems, love and accept her, and will care for her
8. To be surrounded by people who are understanding (providers and relatives)
9. Support to lead a normal life and have children if she so wishes
10. Financial support for follow-up care, including transport
11. A support group, where possible, with whom she can share experiences

Material Support

In addition to emotional support, a woman who has a fistula or is recovering from a fistula repair has material needs, including the following:

1. Nutritious food
2. Personal hygiene products (soap, cosmetics, sanitary pads or clean cloths to contain incontinence)
3. Financial support for her and her children
4. Clean water to drink
5. A clean, protected environment
6. Clean clothes and shoes

Socioeconomic Support

Community organizations and, in some cases, government organizations can assist fistula clients in becoming self-sufficient and reintegrating into their communities by ensuring that they have:

1. Free or affordable services and treatment
2. Access to educational opportunities (literacy/numeracy)
3. Access to income-generating skills development

Participant Handout 8-H

Counseling Checklist for the Client's Family Members

Clinical Intake/Preoperative Management/ Intraoperative Management/Postoperative Management

- Include family members when counseling the fistula client only if the client desires their presence.
- Provide information about the client's condition and treatment only if the client is present and/or requests that this information be shared with family members.
- Assess the family member's ability or capacity to give and receive information.
- Assess the family member's ability or capacity to provide support to the client.
- Explore the family member's needs and feelings.
- Provide information about the following, as appropriate:
  - Client's needs (e.g., informational, emotional, and social needs, and prevention of recurrence)
  - Ways to support the client
  - Hospital routines and procedures
  - Client social support groups within the facility
  - If condition is not treatable, information on community support networks and how to support her as she goes about her life

Discharge and Follow-Up

- Include family members when counseling the fistula client only if the client desires their presence.
- Provide information about the client's condition and treatment only if the client is present and/or requests that this information be shared with family members.
- Explore family members' feelings, questions, and concerns after the procedure; provide support and encouragement.
- Provide information on possible side effects, risks, and warning signs, and develop a plan in case of complications.
- Provide information on the client's needs and ways to support the client.
- Provide information on how the client needs to take care of herself at home, including the following measures:
  - Necessary period of abstinence
  - Delaying pregnancy and available contraceptive methods, as appropriate
  - Need to seek antenatal care as soon as she knows she is pregnant, and to set up birth preparedness and complication readiness
  - Plan for follow-up visits and importance of follow-up
- Discuss reproductive tract infections and sexually transmitted infections, including HIV
- Discuss sexuality after surgical repair, as appropriate.
- Provide links to community organizations, where available.
- Discuss income-generating activities and educational opportunities, if possible and/or available.

Session 9
Supporting the Fistula Client

Refer to pages 184 through 187 of the traumatic fistula supplement for alternative Session 9 Overview—Session Objectives, Points to Remember, Training Methods, Materials, and Advance Preparation.

Session Objectives

During this session, the participants will:

- Learn how to form client support groups within the facility
- Describe success stories and how to use them to assist women who are at the facility for an intervention
- Locate community support networks, income-generating activities, and educational opportunities (if available)
- Facilitate the client's contact with existing community support networks and access organizations that will assist with income-generating activities and educational opportunities (if such networks and organizations are available)

Note: If there are no community resources or organizations to support clients with, this session can focus solely on the use of success stories in assisting fistula clients.

POINTS TO REMEMBER

- ✓ There is no right or wrong way to organize or develop support groups for obstetric fistula clients. How successful these support groups are will depend on how well they respond to clients' needs and wishes.
- ✓ Clients with current and/or repaired obstetric fistulas can provide an important resource for the development of support groups, success stories, and linking with community services.
- ✓ Providers need to know what community organizations and services are available for obstetric fistula clients so that they can link clients with them after clients are discharged.

Training Methods

- Presentation/discussion
- Brainstorm
- Role play

Materials

- Flipchart paper, easel, markers, and tape
- Flipcharts of the client case studies (from Session 4)
- Flipcharts entitled "Addressing the Client's Feelings" for each client (from Session 4)
- Participant Handout 9-A: Community-Based Organizations
- Props for role-plays, such as client-education materials, a blanket, a curtain, drapes, or other materials that can be used to make the role-plays more realistic
- Video camera and television or monitor (optional)

Advance Preparation

1. Prepare a flipchart listing the objectives of this session.
2. Organize the following guest speakers/presenters:
   - Invite a client or provider responsible for facility-based client support groups to make a presentation about how the support group was started and how it functions.
   - If possible, include at least two current or former fistula clients who are willing to work with workshop participants to develop a strategy for using success stories. If necessary, negotiate an honorarium for the clients who come to assist with this session.
   - Invite representatives of community-based organizations that work with fistula clients to make a presentation about different organizations, opportunities provided by the organizations, and ways to contact the organizations.
3. Make one copy of Participant Handout 9-A for each participant. If no community organizations are available, skip this step.
4. Prepare the following flipcharts:
   - "Potential Benefits of Facility-Based Client Support Groups"
   - "Approaches to Developing Facility-Based Support Groups"
   - "Community-Based Organizations" with two columns: "Name" and "Resources"
5. Prepare the room so that each group can sit near its respective case-study and feelings flipcharts.
6. Gather the materials and prepare the room for practice role plays.
7. Set up the video camera and television or monitor (optional).

Session 9 Training Steps

Session Time (total): 3 hours, 30 minutes

PART A: FORMING CLIENT SUPPORT GROUPS WITHIN A FACILITY

Time: 1 hour

Activity 1: Brainstorm/Discussion *(15 minutes)*

1. Introduce any guests who have come for the session.
2. Briefly review objectives of the session.
3. Ask the participants to brainstorm possible benefits of a facility-based client support group. Write their responses on the prepared flipchart entitled "Potential Benefits of Facility-Based Client Support Groups," and post the flipchart on the wall.
4. Ask the guests if they have any additions to the list. Complete the list, as necessary.

TRAINING TIP

Emphasize the following theoretical benefits of support groups:

- They provide an opportunity for the woman to see that she is not alone.
- Support groups offer clients a chance to receive reassurance, hope, and encouragement from other clients and providers, especially if the client did not receive this from family members.
- They also offer clients a chance to see and talk with women who have successfully completed treatment.
- Support groups also provide opportunities for peer education/health education about the cause of the fistula, what the provider will be doing during the course of treatment, why menstruation has ceased (if it has), why some women have multiple fistulas, what happens during surgery, whether it is possible to undergo successful repair after numerous failed attempts, how long a woman has to wait to resume physical work, and so on.
- They give clients opportunities to discuss fears, concerns, and questions.
- They also offer clients opportunities to openly discuss their feelings about the fistula, about being isolated or abandoned, about reintegration, about their chances for having a successful sexual relationship, and about their chances for future fertility.

Refer to page 188 of the traumatic fistula supplement for additional points to discuss regarding support groups.

Activity 2: Presentation/Discussion by a Guest Speaker from a Client Support Group (Organizer/Manager) *(25 minutes)*

***Note:* Activity 2 is only appropriate if a guest is available to speak about client support groups, since the presentation is from the perspective of an organizer of a client support group to explain how the support group is organized and how it functions. If no speaker has been invited, move on to Activity 3.**

1. Introduce the speaker, who will present a 15-minute talk on client support groups in his or her facility. (See the Training Tip below for an outline of the presentation.)
2. Thank the speaker and give the participants 10 minutes to ask questions, request clarifications, or share their personal experiences with facility-based support groups for fistula clients.
3. Finish the discussion by emphasizing that the success of support groups depends on their ability to maintain privacy and confidentiality for all members and on their ability to respond to the specific needs of the group members.

Activity 3: Small-Group/Large-Group Work *(20 minutes)*

1. Divide the group into three smaller groups and ask them to develop a list of different ways to organize client support groups. Ask each group to elect a reporter to present the group's list to the large group. Give each group markers and a piece of flipchart paper to write on.
2. Ask the guest to circulate among the groups as they discuss support groups. Make sure that you are also circulating.

TRAINING TIP

Some possible approaches to developing facility-based client support groups include:

- Assign a recovering fistula client to a newly admitted client, to serve as her "preceptor/sister" through the process; do the same for caregivers.
- Organize a welcome/orientation group for newly admitted women; topics to be discussed could include self-care, preop routines, surgical procedures, estimated length of recovery, and surgical success rates.
- Organize a "preparation for discharge" group for women who will be discharged in the near future; topics to discuss could include self-care, sexual abstinence, family planning, future fertility, follow-up care, sexuality after the fistula repair, and community groups.
- Develop special groups for teenagers, women who have had an unsuccessful repair, women who have been abandoned, older women, and family members, to address the special needs of these individuals.

(continued)

TRAINING TIP *(continued)*

- Plan for a regular time when women can gather informally. For example, let women know that they can meet for discussion every day in the afternoon at a specified place where they will not be interrupted or overheard.
- Plan for a regular time when specific themes will be discussed and those interested can participate. For example, develop a series of themes that are presented at an appointed time.
- Access information to link women with income-generation and/or social or legal services.

Refer to pages 189 and 190 of the traumatic fistula supplement for additional points to discuss regarding developing facility-based support groups, and Supplemental Handout 9-a, to be distributed at this point in the activity.

3. After 10 minutes, ask the groups to reconvene. Ask the reporters to take turns listing one possible approach to developing facility-based client support groups from their lists until all of the ideas have been exhausted. Write their responses on the flipchart entitled "Approaches to Developing Facility-Based Client Support Groups," and post the flipchart on the wall.
4. Ask the guests if they have any additions to the list. Complete the list, as necessary.
5. Summarize by emphasizing that there is no right or wrong way to organize or develop support groups for fistula clients. The success of these groups will depend on how well they respond to clients' needs and wishes.

PART B: USING SUCCESS STORIES

Sometimes when an individual is in a challenging circumstance, such as living with a fistula, it can be inspiring for that person to learn about how someone else successfully dealt with a similar situation. The following three activities explore strategies to help inspire fistula clients, based on other women's stories of having coped successfully with this condition.

Time: 1 hour, 30 minutes

Activity 1: Presentation *(30 minutes)*

1. Introduce the guest speakers (who are recovering/repaired fistula clients). Ask each woman to briefly describe her situation, as she feels comfortable, and then to explain:
   - The kinds of success stories that were particularly helpful to her
   - When the use of success stories was particularly helpful to her

- Who shared the success stories—i.e., providers or treated clients themselves
- How these success stories were helpful in her healing process
- If success stories were not shared with the client during her stay at a facility, what kinds of things she would have liked to hear?

2. Thank the speakers and give the participants time to ask them questions about the use of success stories as a part of counseling women with fistula.

Activity 2: Role-Play Preparation *(10 minutes)*

1. Divide the participants into the same case-study client groups to which they were assigned in Session 4, seating each group near its case-study and feelings flipcharts.
2. Give each group a different stage of service delivery (i.e., clinical, admission to ward and preop, immediate postop [first 14 days], and discharge/follow-up). Ask each group to develop a five-minute role play for using a success story during their assigned stage in service delivery. (Participants can develop role plays with either a provider or a fistula client presenting the success story.)
3. Distribute props to each group.
4. Walk around the room and offer help as the participants develop their role plays.

Activity 3: Role-Play Practice *(40 minutes)*

1. Let each group conduct its role play for the other participants to observe.
2. Introduce the role play by reminding the participants of the circumstances of the counseling scenario.
3. Stop the role play if it exceeds the five-minute time limit.
4. Discuss each role play (5 minutes), asking:
   - How do you think the "client" felt during this role play?
   - Was the success story appropriate to the stage of service delivery?
   - Was the success story appropriate for the client's particular needs?
   - What did the group do well? Start by asking the group to evaluate themselves; then ask other participants for their feedback, and finish by providing a summary of positive feedback.
   - How could they improve (both the technique and the content)? Start by asking the group to evaluate themselves. Then ask other participants for their feedback, and finish by providing a summary of how to improve.
5. Summarize the feedback and add any points that were not covered by the participants.

Activity 4: Discussion *(10 minutes)*

1. Summarize the use of success stories by asking these questions:
   - What did you learn from this session?
   - How could you apply what you have learned in your own work setting?
2. Be prepared to conduct your own demonstration role play in case key steps or skills need to be reinforced.

PART C: CONTACTING COMMUNITY SUPPORT NETWORKS

Note: **Part C is only appropriate if the trainer has established that there are community support networks available to fistula clients. If there are no such networks, move on to Session 10.**

Refer to pages 191 through 194 of the traumatic fistula supplement, Supplement 9A, Linkages with the Community, which should be covered at the start of Part C.

Time: 1 hour

Activity 1: Large-Group Exercise/Discussion *(20 minutes)*

1. Introduce any guests who have come for the session.
2. Refer participants to Handout 8-G.
3. Ask the participants to brainstorm possible community organizations that work with women with fistulas in the communities where they work and write their responses on the prepared flipchart For each organization listed, ask the participants to list (in the "Resources" column) the services the organization provides, or could provide, for women with fistulas. Post the flipchart.
4. Ask the guests if they have any additions to the list. Complete the list, as necessary.
5. Provide participants with a copy of Handout 9-A and task them with following-up in their own communities to identify organizations that might support fistula clients.

Activity 2: Presentation/Discussion *(20 minutes)*

1. Introduce the speaker, who will present a 15-minute talk on the community-based organization he or she represents. (See the Training Tip below for an outline of the presentation.)
2. Thank the speaker and give the participants five minutes to ask questions or get clarification.

TRAINING TIP

The presentation on community-based organizations should include the following information:

- Where does the organization work?
- What kind of support does this organization offer to fistula clients (clients awaiting repair, repaired clients, and/or clients whose fistula could not be repaired)?
- What kind of opportunities does the organization offer to fistula clients?
- How can fistula clients contact the organization?
- Once a woman is assisted by the organization, does the organization monitor her progress? If so, how?
- Does the organization have a formal relationship with hospitals that provide obstetric fistula repair surgery?
- Does the organization go out into the community to look for fistula clients?

Activity 3: Small-Group Work/Discussion *(20 minutes)*

1. Divide the group into three smaller groups and ask them to come up with a list of different ways to ensure that fistula clients are connected with community-based organizations. Ask each group to elect a reporter to present their list to the large group. Give each group markers and a flipchart to write on.

TRAINING TIP

Ways to ensure that fistula clients get in touch with community-based organizations include the following:

- Have representatives of community-based organizations make regularly scheduled visits to the hospital to meet with women in the hospital.
- Assign one staff person in the hospital to make sure that the hospital staff have a regularly updated list of community-based organizations that work with fistula clients.
- Include representatives of community-based organizations in counseling sessions in the postoperative period and when preparing for discharge.

(continued)

TRAINING TIP *(continued)*

- Include education about community-based organizations and how to contact them in counseling sessions in the postoperative period.
- Have women who have successfully collaborated with community-based organizations share their stories.
- If outreach services are available, coordinate home visits with representatives of the community-based organizations conducting them.

2. Ask the guest to circulate among the groups during their discussion. Make sure that you are also circulating.
3. After 10 minutes, ask the groups to reconvene. Ask the reporters to take turns listing one possible way to connect clients with community-based organizations until all of the ideas have been exhausted. Write their responses on the flipchart.
4. Ask the guest if he or she has any additions to the list. Complete the list, as necessary.
5. Summarize by emphasizing the importance of working with community-based organizations to help fistula clients reintegrate into their communities and/or be self-sufficient.

Distribute Supplemental Handout 9-b: Examples of Community-Based Client Support (pages 195 through 197 of the traumatic fistula supplement). This handout offers notable examples of community-support efforts in countries where traumatic fistula is a problem.

Refer to pages 198 through 201 of the traumatic fistula supplement, Supplement 9B, Part D: Involvement of Men as Partners at the Community Level, an additional Session 9 topic that should be addressed at this point.

Session 9
Handouts

Participant Handout 9-A

Community-Based Organizations

Organization	Representative	Contact Information	Resources
1.			
2.			
3.			
4.			
5.			
6.			
7			
8.			
9.			
10.			

Session 10
Clinical Practicum

Session Objectives

During this session, participants will:

- Practice counseling skills with actual fistula clients and their family members (when appropriate)
- Provide feedback and discuss lessons learned in skills practice
- Show improvements in clinical performance according practice standard

POINTS TO REMEMBER

- ✓ Greet the woman respectfully and with kindness, and introduce yourself.
- ✓ Ensure that the woman will have the comfort, privacy, dignity, empathy, respect, and confidentiality she needs.
- ✓ Assess whether counseling is appropriate at the time; if it is not, arrange for her to be counseled at another time.
- ✓ Remember to use effective interpersonal communication skills (including two-way communication, listening, and verbal and nonverbal communication).
- ✓ Encourage the client to talk.
- ✓ Provide fistula information that is complete and accurate.

Training Methods

- Practicum (during normal clinic or hospital hours)
- Large-group discussion

Materials

- Flipchart paper, easel, markers, and tape
- Participant Handout 10-A: Sample Counseling Learning Guides
- Participant Handout 10-B: Counseling Observation Checklist

Advance Preparation

1. Prepare a flipchart listing the objectives of this session.
2. Schedule practicum assignments with the service site well in advance.
3. Review all handouts and make one copy for each participant.
4. Gather client-education materials on postprocedure care, family planning, and other appropriate topics.
5. Obtain permission from site staff and clients for the participants to counsel the clients.
6. Assign each participant to a supervisor or trainer.

Session 10 Training Steps

Session Time (total): 1 day to 1½ days

Activity 1: Presentation/Discussion *(30 minutes)*

1. Present an overview of the practicum process:
   - The participants will work individually with fistula clients, preferably seeing a client through all six stages of service delivery. Supervision, either by a site staff person or by a member of the training team, will be provided at all times.
   - The participants will be assigned to work together in teams of two throughout the day, with one observing whenever the other is counseling. The observer should fill out Participant Handout 10-B immediately following the observation or during breaks in counseling. (Note: During the practicum, the participants can also refer to the sample learning guides in Participant Handout 10-A.)
   - It should be explained to the client that this is a counseling training activity and the client's permission for the three individuals to be present should be requested.
2. Distribute and review Participant Handouts 10-A and 10-B.

Activity 2: Practicum *(during Normal Clinic or Hospital Hours)*

1. Instruct the participants and trainers to arrive at the site before the fistula clients are prepared for surgery, so the trainees can be involved in immediate preoperative counseling.

TRAINING TIP

Each participant should counsel *at least* one client during each stage of service delivery. This will allow them to see the range of situations they might encounter and reinforce the lesson that they must tailor their counseling style and content to the particular client.

2. Remind the trainees that they should use the REDI steps as a guide during the counseling sessions.
3. Instruct the participants and trainers to stay onsite as long as there are clients available for counseling. Coordination with site staff is crucial; the presence of the workshop participants and trainers should not delay or interrupt their services.

Activity 3: Discussion *(1 hour)*

1. Discuss the practicum experience at the end of the practicum. To begin, ask each participant to summarize his or her case in two or three sentences.

2. Then ask each participant the following questions:
    - How did it feel to counsel a real client?
    - Do you feel that you communicated effectively with your client?
    - Do you feel that you were able to help the client?
        - If so, in what way were you able to help?
        - If not, what will enable you to help clients in the future?
        - Do you feel like you were sufficiently prepared to talk to the client?
        - If not, what will enable you to talk to clients in the future?
    - What lesson(s) have you learned from the experience that you can apply in your own work setting?
3. Share the observations recorded on the Counseling Observation Checklist (Handout 10-B).
4. Summarize by going around the room and asking the participants how they will apply what they learned in their own work setting:
    - Each participant must identify at least one change that he or she will make in the way he or she works with clients.

TRAINING TIP

As the participants identify the changes they will make in their client-provider interactions as a result of this experience, remind them of the need to integrate these skills into their communication and contact with all clients.

Session 10 Handouts

Participant Handout 10-A

Sample Counseling Learning Guides

Note: The REDI steps should be used as a guide during the counseling sessions. Counselors should use the steps as appropriate during each contact with the client. Additional information has been provided for some of the steps, which are specific to the counseling stage.

Participant's name: _____

Date: ____/____/____

Sample Counseling Learning Guide: First Contact
RAPPORT BUILDING
1. Welcome the client.
2. Make introductions.
3. Ensure confidentiality.
a. *Assess whether counseling is appropriate at this time. (If it is not, arrange for the client to be counseled at another time.)*
4. Introduce the subject of obstetric fistula.
EXPLORATION
1. Explore the client's needs, problems, and concerns.
2. Assess the client's knowledge and give information, as needed.
a. *Provide directions to the appropriate unit.*
b. *Provide information that the client needs about her condition; include any further details requested by the client.*
c. *Address any myths or misconceptions, as appropriate.*
DECISION MAKING (IF APPROPRIATE)
1. Identify decisions the client needs to make in this session.
2. Identify the client's options for each decision.
3. Weigh the benefits, disadvantages, and consequences of each option.
4. Assist the client in making her own realistic decisions.
a. *Share comparable stories or anecdotes, as appropriate.*
IMPLEMENTING THE DECISION (IF APPROPRIATE)
1. Make a concrete, specific plan for carrying out the decision.
2. Identify skills that the client will need to carry out the decision.
3. Practice skills, as needed, with the counselor's help.
4. Make a plan for follow-up.

Participant's name: _____

Date: ____/____/____

Sample Counseling Learning Guide: Clinical Intake

Meet with the clinician who is responsible for the client, and read the clinician's notes about the client, so as to know what the clinical findings are, what laboratory and other investigations are foreseen, what procedures and surgery are contemplated, and the likely prognosis.

RAPPORT BUILDING

1. Welcome the client.

2. Make introductions.

3. Ensure confidentiality.

a. *Assess whether counseling is appropriate at this time. (If it is not, arrange for the client to be counseled at another time.)*

b. *Ask the client if she would like anyone else present during counseling.*

4. Reintroduce the subject of obstetric fistula.

EXPLORATION

1. Explore the client's needs, problems, and concerns.

a. *Explore any attitudes, myths, misconceptions, religious beliefs, fears, and concerns the client has about the surgery.*

2. Assess the client's knowledge and give information, as needed.

DECISION MAKING

1. Identify decisions the client needs to make in this session.

a. *Based on the client's condition and in consultation with surgical team, provide information about the following, as appropriate:*

- *Overall physical condition*
- *Results of physical and pelvic examinations and laboratory tests*
- *Present condition and its causes*
- *Possibility of treatment and/or treatment options and timing*
- *Self-care*
- *Need for referral and transport to another facility*
- *Procedures to be done and their risks and benefits*

b. *If the client's condition is not treatable, provide information on community support networks, and on coping strategies for daily life.*

2. Identify the client's options for each decision.

3. Weigh the benefits, disadvantages, and consequences of each option.

4. Assist the client in making her own realistic decisions.

a. *Share comparable stories/anecdotes as appropriate.*

IMPLEMENTING THE DECISION

1. Make a concrete, specific plan for carrying out the decision.

2. Identify skills that the client will need to carry out the decision.

3. Practice skills with the client, as needed, with the provider's help.

4. Make a plan for follow-up.

a. *Arrange for the client to talk with other obstetric fistula clients, as appropriate.*

b. *Provide information on available client support groups within the facility.*

Participant's name: _____

Date: ____/____/____

Sample Counseling Learning Guide: Admission and Preoperative Period

Meet with the surgeon/surgical staff responsible for the client, or and read their notes about the client so as to know what the clinical findings are, what laboratory and other investigations are foreseen, what procedures and surgery are contemplated, what preoperative preparation is ordered, and the likely prognosis.

RAPPORT BUILDING

1. Welcome the client.

2. Make introductions.

a. *Introduce the client to the ward staff and other clients in the ward.*

3. Ensure confidentiality.

a. *Assess whether counseling is appropriate at this time. (If it is not, arrange for her to be counseled at another time.)*

b. *Ask the client if she would like anyone else present during counseling.*

4. Reintroduce the subject of obstetric fistula.

EXPLORATION

1. Explore the client's needs, problems, and concerns.

a. *Explore any attitudes, myths, misconceptions, religious beliefs, fears, or concerns the client has about the surgery.*

2. Assess the client's knowledge and give information as needed.

a. *Based on the client's condition, and in consultation with surgical team responsible for her care, provide information about the following, as appropriate:*

- *Surgical repair (steps, possible exams or lab tests, expected feelings, consent, success rates, possible side effects, complications, and risks) and the expected length of hospital stay*
- *Type of anesthesia to be used, risks of anesthesia, pain, and what to expect while being anesthetized*

b. *As part of preoperative teaching, do the following:*

- *Prepare the client and her family for the expected events on the day of the surgery*
- *Inform the client and her family of expected tubes, therapies, routines, etc.*
- *Instruct the client in preoperative preparation (e.g., bowel preparation, nutrition)*
- *Instruct the client about activities to prevent postoperative complications*

c. *Address the client's fears of:*

- *Loss of control*
- *The unknown*
- *Anesthesia*
- *Pain*
- *Death*
- *Separation*
- *Disruption of life*
- *Changes in body image or functions*

d. *If the client's condition is not treatable, provide her with information on a treatment plan and on community support networks.*

Participant's name: _____

Date: ____/____/____

Sample Counseling Learning Guide: Admission and Preoperative Period *(continued)*

DECISION MAKING
1. Identify decisions the client needs to make in this session.
a. *Client's role in her own management of the condition.*
2. Identify the client's options for each decision.
3. Weigh the benefits, disadvantages, and consequences of each option.
4. Assist the client in making her own realistic decisions.
a. *Ensure and document informed consent for the surgical treatment:*
• *Client verbalizes understanding of preoperative teaching.*
• Client correctly *demonstrates postoperative exercises (i.e., coughing and deep breathing, and leg exercises).*
b. *Share success stories, as appropriate.*
IMPLEMENTING THE DECISION
1. Make a concrete, specific plan for carrying out the decision.
2. Identify skills that the client will need to carry out the decision.
3. Practice skills, as needed, with the provider's help.
4. Make a plan for follow-up.
a. *Arrange for the client to talk with other obstetric fistula clients, as appropriate.*
b. *Provide information on available client support groups within the facility.*

Participant's name: _____

Date: ____/____/____

Sample Counseling Learning Guide: Intraoperative Period—Spinal Anesthesia

Note: During the procedure, never leave the client alone.
RAPPORT BUILDING
1. Welcome the client.
2. Make introductions.
a. *Introduce the client to the other operating theater staff.*
3. Reintroduce the subject of obstetric fistula and surgery.
4. Ensure confidentiality.
a. *Speak gently and provide reassurance, comfort, and hope.*
EXPLORATION
1. Explore the client's needs, problems, and concerns.
Before the procedure
a. *Reassure the client that you or another caring staff member will be beside her during the entire procedure.*
b. *Ask the client if she would like you to hold her hand or to just sit next to her during the procedure.*
c. *Explain each step of the process in advance.*
During the procedure
a. *Talk reassuringly to the client during the procedure.*
b. *Assess the client's response to anesthesia/surgery and address any fears, concerns, or questions as they occur.*
c. *Provide information on progress, as appropriate.*
2. Assess the client's knowledge and give information, as needed.
Before the procedure
a. *Provide information on the type of anesthesia to be used, the risks of anesthesia, pain, and what to expect while being anesthetized.*
b. *Discuss how she will feel as the spinal anesthesia wears off.*
c. *Discuss pain management.*
Immediately after the procedure
a. *After consulting with the surgeon/surgical staff, review the outcome of surgery.*
b. *Discuss again, or update as appropriate, immediate postoperative procedures.*
c. *Ask the client if she has any questions, and answer these appropriately.*
DECISION MAKING (AS APPROPRIATE)
1. Identify decisions the client needs to make in this session.
2. Identify the client's options for each decision.
3. Weigh the benefits, disadvantages, and consequences of each option.
4. Assist the client in making her own realistic decisions.
IMPLEMENTING THE DECISION (AS APPROPRIATE)
1. Make a concrete, specific plan for carrying out the decision.
2. Identify skills that the client will need to carry out the decision.
3. Practice skills with the client, as needed, with the provider's help.
4. Make a plan for follow-up.

Participant's name: _____

Date: ____/____/____

Sample Counseling Learning Guide: Intraoperative Period—General Anesthesia

Note: Do not leave the client alone until she is fully anesthetized.
RAPPORT BUILDING
1. Welcome the client.
2. Make introductions.
a. *Introduce the client to the other operating theater staff.*
3. Introduce the subject of obstetric fistula.
4. Ensure confidentiality.
a. *Speak gently and provide reassurance, comfort, and hope.*
EXPLORATION
1. Explore the client's needs, problems, and concerns.
Before the procedure
a. *Reassure the client that you will be beside her until she is fully anesthetized.*
b. *Ask the client if she would like you to hold her hand or to just sit next to her during the procedure.*
c. *Explain each step of the process before anything is performed (pre-anesthesia).*
2. Assess the client's knowledge and give information, as needed.
Before the procedure
a. *Provide or review information on the type of anesthesia to be used, the risks of anesthesia, pain, and what to expect while being anesthetized.*
b. *Discuss how she will feel as general anesthesia wears off, side effects, and management of pain.*
Immediately after the procedure
a. *After consulting with the surgeon/surgical staff, review the outcome of surgery.*
b. *Discuss immediate postoperative procedures.*
c. *Ask the client if she has any questions, and answer these appropriately.*
DECISION MAKING (AS APPROPRIATE) ***Note: The counselor must wait until the client is fully awake and fully oriented and able to make decisions.***
1. Identify decisions the client needs to make in this session.
2. Identify the client's options for each decision.
3. Weigh the benefits, disadvantages, and consequences of each option.
4. Assist the client in making her own realistic decisions.
IMPLEMENTING THE DECISION (AS APPROPRIATE)
1. Make a concrete, specific plan for carrying out the decision.
2. Identify skills that the client will need to carry out the decision.
3. Practice skills, as needed, with the provider's help.
4. Make a plan for follow-up.

Participant's name: _____

Date: ____/____/____

Sample Counseling Learning Guide: Postoperative Period

RAPPORT BUILDING
1. Welcome the client.
2. Make introductions.
a. *Introduce the client to the other operating theater staff.*
3. Ensure confidentiality
a. *Assess whether counseling is appropriate at this time. (If it is not, arrange for the client to be counseled at another time.)*
b. *Ask the client if she would like anyone else present during counseling*
4. Reintroduce the subject of obstetric fistula.
EXPLORATION
1. Explore the client's needs, problems, and concerns.
a. *Explore any attitudes, myths, misconceptions, or religious beliefs that the client might have about the surgery.*
2. Assess the client's knowledge and give information, as needed.
a. *Based on the client's condition and in consultation with the surgical team, provide information about the following, as appropriate:*
• *Postoperative routines*
• *Outcome of surgery*
• *Self-care*
• *Catheter care*
• *Position and mobility*
• *Nutrition*
• *Pain relief*
• *Complications/danger signs*
• *Physiotherapy (if necessary)*
• *Necessary period of abstinence from sex*
• *Need for careful antenatal care and hospital delivery (likely elective, and not emergency, cesarean operation) for future pregnancies*
• *Availability of sexual and reproductive health services (including family planning)*
DECISION MAKING
1. Identify decisions the client needs to make in this session.
a. *Support participation in available client support groups within the facility, or if she is not yet participating, provide information on available client support groups within the facility.*
2. Identify the client's options for each decision.
3. Weigh the benefits, disadvantages, and consequences of each option.
4. Assist the client in making her own realistic decisions.
IMPLEMENTING THE DECISION
1. Make a concrete, specific plan for carrying out the decision.
2. Identify skills that the client will need to carry out the decision.
3. Practice skills with the client, as needed, with the provider's help.
4. Make a plan for follow-up.

Participant's name: _____

Date: ____/____/____

Sample Counseling Learning Guide: Discharge/Follow-Up

RAPPORT BUILDING
1. Welcome the client to the session.
2. Make introductions.
a. *Introduce the client to the other ward or counseling staff if she had never met them during her stay in hospital.*
3. Ensure confidentiality.
a. *Assess whether counseling is appropriate at this time. (If it is not, arrange for the client to be counseled at another time.)*
b. *Ask the client if she would like anyone else to be present during counseling.*
4. Introduce the subject of obstetric fistula.
a. *If the surgery was successful, provide congratulations on the successful outcome of the surgery.*
EXPLORATION
1. Explore the client's needs, problems, and concerns.
a. *Explore any attitudes, myths, misconceptions, religious beliefs, fears, and concerns the client might have about the surgery.*
2. Assess the client's knowledge and give information, as needed
a. *Give the client written postprocedure information.*
DECISION MAKING IF SURGERY WAS SUCCESSFUL
1. Identify decisions the client needs to make in this session.
a. *Remind the client of possible side effects, risks, and warning signs, and develop a plan in case complications or warning signs occur.*
b. *Discuss with the client how to take care of herself at home:*
• *Observing the necessary period of abstinence from vaginal intercourse (plus rectal, if rectovaginal fistula was repaired), to prevent damage to surgical repair, and refraining from introducing foreign bodies (e.g., tampons) into the vagina*
• *Delaying pregnancy*
• *Managing stress incontinence*
c. *Discuss reproductive tract infections and HIV and other sexually transmitted infections.*
d. *Remind the client of the importance of follow-up.*
2. Identify the client's options for each decision.
a. *Discuss available contraceptive methods, as appropriate.*
3. Weigh the benefits, disadvantages, and consequences of each option.
4. Assist the client in making her own realistic decisions.

Participant's name: _____

Date: ____/____/____

Sample Counseling Learning Guide: Discharge/Follow-Up *(continued)*

DECISION MAKING IF SURGERY WAS UNSUCCESSFUL
1. Identify decisions the client needs to make in this session.
a. *Based on the client's condition, provide information about the following, as appropriate:*
• *Personal hygiene and good nutrition*
• *Managing incontinence (e.g., special exercises)*
• *Messages on delaying pregnancy/family planning/contraceptive choices (if desired)*
• *Possible complications and/or infection and what her options are*
• *Cost-effective sources of supplies (e.g. pads, colostomy bags)*
2. Identify the client's options for each decision.
a. *Discuss available contraceptive methods, as appropriate.*
3. Weigh the benefits, disadvantages, and consequences of each option.
4. Assist the client in making her own realistic decisions.
IMPLEMENTING THE DECISION
1. Make a concrete, specific plan for carrying out the decision.
a. *Provide links to community organizations, where available.*
2. Identify skills that the client will need to carry out the decision.
3. Practice skills, as needed, with the providers help.
4. Make a plan for follow-up.

Participant Handout 10-B

Fistula Counseling Competency-Based Observation Checklist

Introduction to Client

Good (morning, afternoon), my name is _____. I am here to support _____ (the participant/trainee) to improve the quality of services at this site. I would like to observe your session/procedure today.

Do you have any questions for me?

May I stay for this session/procedure?

Name of provider: _____

Name of observer: _____

Client number: _____

Codes

0—unsatisfactory
1—satisfactory, but needed prompting
2—satisfactory without prompting

Scoring

1. *Maximum score=14*
2. Passing score=____ (should be determined locally—e.g., minimum 10 out of 14)
3. Questions marked with a "**": Provider must score at least a 1 on this observation item to pass.

What kind of counseling was provided?

- ☐ Clinical intake
- ☐ Admission and preoperative
- ☐ Intraoperative
- ☐ Postoperative
- ☐ Discharge and follow-up

1. Does the provider ensure an acceptable level of privacy, confidentiality, and client dignity?**
   0
   1
   2

Observer remarks: _____

_____

_____

2. Does the provider make the client feel comfortable? (Describe.)
   0
   1
   2

Observer remarks: _____

_____

_____

3. Does the provider try to explore the client's feelings?
   0
   1
   2

Observer remarks: _____

_____

_____

4. Does the provider use effective interpersonal communication (including two-way communication, listening, and verbal and nonverbal communication)?

   0

   1

   2

Observer remarks:_____

_____

_____

5. Does the provider encourage the client to talk (e.g., to ask questions or express feelings)?

   0

   1

   2

Observer remarks:_____

_____

_____

6. Is the fistula information provided to the client complete and accurate?**

   0

   1

   2

Observer remarks:_____

_____

_____

7. What is the overall provider-client interaction like?**

   0

   1

   2

Observer remarks:_____

_____

_____

Total score: _____

Session 11
Workshop Wrap-Up

Refer to pages 206 through 210 of the traumatic fistula supplement for alternative Session 11 Overview—Session Objectives, Points to Remember, Training Methods, Materials, and Advance Preparation.

Session Objectives

During this session, the participants will:

- Complete a posttest
- Discuss training follow-up plans
- Evaluate the effectiveness of the workshop in achieving its objectives
- Share closing thoughts and impressions

Training Methods

- Discussion

Materials

- Flipchart paper, easel, markers, and tape
- Appendix B: Posttest
- Handout 11-A: Home Site Implementation Plan
- Appendix J: Workshop Evaluation Form
- Certificates of attendance for the participants
- Refreshments

Advance Preparation

1. Make enough copies of Appendix B and Handout 11-A for distribution to the participants.
2. Send invitations to guests.

3. Provide speakers with the workshop goals and objectives and some general achievements (e.g. clients attended to, interaction with site, whether the participants did generally well, etc.), so they have some context for their remarks.
4. Ask the participants to select a representative to speak on their behalf.
5. Prepare a certificate of attendance for each participant.
6. Review **Appendix J: Workshop Evaluation Form** and make one copy for each participant.
7. Plan follow-up efforts.

Session 11 Training Steps

Time: 2 hours and 30 minutes; 30 minutes for closing ceremony (depending on local protocol for closing)

Refer to pages 211 through 225 of the traumatic fistula supplement. This includes:

- *Supplement 11A: Supporting the Provider, which addresses an additional topic that should be covered at the start of this session.*
- *Supplemental Handouts 11-a, 11-b, and 11-c, which are used during the Supporting the Provider activities*

Activity 1: Posttest *(45 minutes)*

1. Distribute Appendix B and ask the participants to complete it.

Refer to pages 9 through 11 of the traumatic fistula supplement for alternative Appendix B—Pretest/Posttest on Fistula Counseling, which replaces the one in this curriculum, or use the adapted pretest/posttest that you used on Day 1 of the training.

2. Mark the posttests and share the results with the participants after Group Work/Discussion

Refer to pages 15 through 18 of the traumatic fistula supplement for alternative Appendix C—Pretest/Posttest on Fistula Counseling Answer Key, which replaces the one in this curriculum.

Activity 2: Group Work/Discussion *(1 hour, 30 minutes)*

1. Organize the group into teams from the same facility, if possible.
2. Distribute copies of Appendix 11-A for the teams to complete.
3. Ask each group to develop a **Home Site Implementation Plan** (HSIP) for their site (e.g., they should record what changes they plan to make at their work site as a result of this training).

Note: Each HSIP must include a section on informed consent. Based on the informed consent content covered during the training, specify the steps that will be taken to establish or strengthen informed consent practices within fistula care services.

4. Select the recorder and presenter for the plenary.
5. Ask the participants to record their plan on Handout 11-A and to write their responses on a flipchart to present to the group.
6. Ask the participants to present the three most important actions from their plan
7. Remind the participants to include their name on their work.
8. The trainer will retain the participant flipcharts.
9. Explain that the training team, the workshop organizers, and/or supervisors will visit each site within three months of completion of the training to:
    - Assess the participants' progress in making the desired changes
    - Identify barriers to counseling fistula clients
    - Provide technical assistance to help overcome these barriers

TRAINING TIP

While the participants are presenting their implementation plans, have a co-trainer or support person word-process the plans; these can be printed and given to the participants before the close of the session, for them to use upon their return to their home facility. It will also be a record for the trainer to refer to in preparation for the posttraining follow-up visit.

Note: During posttraining follow-up visits, be sure to check on the status of informed consent practices being carried out as a result of the HSIP.

Make specific follow-up plans with the participants and their supervisors **at the time of the training**. Confirm these plans *before* conducting this session.

Activity 3: Participants' Individual Written Evaluation *(15 minutes)*

1. Distribute the Workshop Evaluation Form to each participant.
2. Allow the participants approximately 15 minutes to complete the handout.
3. Collect the evaluation forms.

Activity 4: Closing Ceremony *(up to 25 minutes, depending on local protocol)*

1. Conduct a closing ceremony in a manner appropriate to local customs; observe all necessary protocols.
2. Distribute the certificates of attendance.

Participant Handout 11-A:

Home Site Implementation Plan

What changes can you make at your site to improve counseling for fistula clients?

What barriers do you anticipate that would affect your ability to implement these changes?

What action steps can you propose to address each barrier identified?

Summary of action steps:

Action Steps	Resources	Who will do this—look at COPE action plan	Due Date	Expected Outcomes/ Comments

Appendixes

Appendix A

Training Outline

Session	Participants	Time
Session 1: Opening Session		
Part A: Registration and Pretest	All	30 minutes
Part B: Opening Ceremony	All	30 minutes
Part C: Workshop Introduction	All	1 hour, 20 minutes
Session 2: Providers' Values and Attitudes	All	
Part A: Informed Choice, Informed Consent, and the Rights of the Client	All	20 minutes
Part B: Values and Attitudes	All	1 hour, 45 minutes
Session 3: Understanding Obstetric Fistula		
Part A: Description of the Problem	Nonphysicians	20 minutes
Part B: Causes of Obstetric Fistula	Nonphysicians	15 minutes
Part C: Health and Social Consequences of Obstetric Fistula	Nonphysicians	20 minutes
Part D: Reasons Why Women Do Not Seek Care	Nonphysicians	20 minutes
Part E: Prevention of Obstetric Fistula	Nonphysicians	20 minutes
Session 4: Understanding the Client's Perspective		
Part A: Developing Case Studies of Obstetric Fistula Clients		
Option 1: Original Case Studies	Nonphysicians	1 hour, 30 minutes
Option 2: Adapted Case Studies	Nonphysicians	25 minutes
Part B: Confidentiality, Privacy, and Dignity	All	45 minutes
Part C: Addressing the Client's Feelings	All	1 hour, 35 minutes
Part D: Sexuality Issues	All	25 minutes

Training Outline *(continued)*

Session	Participants	Time
Session 5: Interpersonal Communication		
Part A: Two-Way Communication	All	30 minutes
Part B: Verbal and Nonverbal Communication	All	30 minutes
Part C: Active/Effective Listening	All	35 minutes
Part D: Asking Open-Ended Questions	All	45 minutes
Part E: Using Simple Language and Visual Aids	All	1 hour, 30 minutes
Part F: Counseling Framework: REDI	All	50 minutes
Session 6: Counseling for the Obstetric Fistula Client		
Part A: Overview of Counseling	All	45 minutes
Part B: Counseling for Obstetric Fistula Clients	All	1 hour, 30 minutes, to 1 hour, 35 minutes
Part C: Counseling Women with Special Needs	All	55 minutes
Session 7: Family Planning Information and Counseling		
Part A: Rationale	All	40 minutes to 55 minutes
Part B: Informed Choice	All	30 minutes
Part C: Individual Client Circumstances	Nonphysicians	1 hour
Session 8: Counseling for the Client's Family		
Part A: Overview of Counseling for the Client's Family	All	1 hour, 5 minutes
Part B: Counseling during Admission and the Preoperative Period	Nonphysicians	1 hour to 1 hour, 5 minutes
Part C: Counseling after Surgery	Nonphysicians	1 hour to 1 hour, 5 minutes
Part D: Counseling at Discharge	Nonphysicians	1 hour to 1 hour, 5 minutes
Session 9: Supporting the Obstetric Fistula Client		
Part A: Forming Client Support Groups within a Facility	Nonphysicians	1 hour
Part B: Using Success Stories	Nonphysicians	1 hour, 30 minutes
Part C: Contacting Community Support Networks	Nonphysicians	1 hour
Session 10: Clinical Practicum		
Session 11: Workshop Wrap-Up		

Appendix B

Pretest/Posttest on Obstetric Fistula Counseling

1. State the three elements that form the core of a comprehensive approach to helping women with obstetric fistula and their families. (3 points)
   1. _____
   2. _____
   3. _____

2. When could counseling of the obstetric fistula client happen?
   a. Before, during, and after the surgery
   b. Any time you come into contact with the client
   c. Only after the client has been admitted for surgery
   d. When you have extra time with nothing else to do
   e. Both a & b

3. Where does counseling for the obstetric fistula client happen?
   a. In a private room with a door
   b. Anywhere in the service site where confidentiality and privacy can be ensured
   c. At a community meeting place
   d. None of the above
   e. Both a & b

4. Give one example of how you can respect an obstetric fistula client's privacy when providing counseling:

5. Two-way communication happens when:
   a. Both client and provider talk alternately
   b. Both client and provider listen alternately
   c. Both a & b
   d. None of the above

6. Give two examples of open-ended questions.
   1. _____
   2. _____

7. Give two signs of effective listening. (How can you tell someone is listening attentively?)
   1. _____
   2. _____

8. What is the minimum information on family planning that you should tell every obstetric fistula client before she is discharged?

   _____
   _____
   _____
   _____

9. List three methods of family planning that might be inappropriate for a woman after a surgical repair for obstetric fistula.
   1. _____
   2. _____
   3. _____

10. Informed choice means (check all answers that are true):
    - ☐ The client has been given full information.
    - ☐ The client cannot leave the service site without choosing a family planning method.
    - ☐ The provider helps the client to make a decision.
    - ☐ Family members motivate the client to choose a particular family planning method.

11. What is empathy?

_____

_____

_____

_____

12. Give two examples of how to create a more comfortable environment for counseling.

1. _____
2. _____

13. A woman arrives at your site with an obstetric fistula that occurred following obstructed labor. Using simple language, explain to the client what is happening in her body.

_____

_____

_____

_____

14. Explain how beliefs can influence the care that providers give. Give one concrete example of a belief, value, or judgment about obstetric fistula and how this could affect care.

_____

_____

_____

_____

15. List three important issues to address when counseling the obstetric fistula client and her partner together.

1. _____
2. _____
3. _____

16. List three issues that might be better explored in a counseling session with client alone, rather than with her and her partner together.

1. _____
2. _____
3. _____

Appendix C

Pretest/Posttest on Obstetric Fistula Counseling *Answer Key*

1. State the three elements that form the core of a comprehensive approach to helping women with obstetric fistula and their families. (3 points)

   1. Maintaining community and service-provider partnerships—to reduce the number of adolescent pregnancies by encouraging later marriage and expanding access to family planning services

   2. Improving access to good obstetric care, including emergency care

   3. Providing surgical treatment and counseling to women with fistulas

2. When could counseling of the obstetric fistula client happen? (1 point)

   a. Before, during, and after the surgery

   b. Any time you come into contact with the client

   c. Only after the client has been admitted for surgery

   d. When you have extra time with nothing else to do

   e. **Both a & b**

3. Where does counseling for the obstetric fistula client happen? (1 point)

   a. In a private room with a door

   b. Anywhere in the service site where confidentiality and privacy can be ensured

   c. At a community meeting place

   d. None of the above

   e. **Both a & b**

4. Give one example of how you can respect an obstetric fistula client's privacy when providing counseling: (2 points)

   Possible responses include:

   - **Speaking in a low voice**
   - **Talking to the client in a private room or space (if possible)**
   - **Not sharing the details of her case with others unless necessary**

5. Two-way communication happens when: (1 point)

   a. Both client and provider talk alternately

   b. Both client and provider listen alternately

   c. **Both a & b**

   d. None of the above

6. Give two examples of open-ended questions. (2 points)

   Possible responses include:

   - **How did you feel when you first found out you were leaking urine?**
   - **What did you do after you first noticed you were leaking urine?**
   - **How do you feel now?**
   - **What do you think is going to happen while you are here?**
   - **What concerns do you have?**
   - **What questions or concerns does your husband or partner have about your condition?**

7. Give two signs of effective listening. (How can you tell someone is listening attentively?) (2 points)

   Possible responses include:

   - **Being attentive to the speaker; not doing other tasks at the same time, and not interrupting**
   - **Asking questions**
   - **Showing empathy**
   - **Reflecting (i.e., repeating, using your own words, to confirm understanding)**
   - **Interpreting the feelings and emotions behind what is being said**
   - **Integrating what has been said into further discussion**
   - **Not talking to other people while listening**
   - **Showing a genuine interest in the topic**
   - **Maintaining eye contact with the speaker (within cultural norms)**

8. What is the minimum information on family planning that you should tell every obstetric fistula client before she is discharged? (5 points)
   - **To prevent damage to the surgical repair of the fistula, she should be abstinent and avoid putting anything in the vagina for at least three months following the procedure.**
   - **If she has had amenorrhea, her menstrual period may return between two and four months after successful surgical repair. She could ovulate before her first menstrual period and is therefore at risk of becoming pregnant before her menses return.**
   - **She should start using a family planning method before becoming sexually active.**
   - **Some women might have secondary infertility after the obstetric fistula. She should assume that she is fertile until proven otherwise.**
   - **She needs to know where and how to get family planning services (either while in the hospital or after discharge).**

9. List three methods of family planning that might be inappropriate for a woman after a surgical repair for obstetric fistula. (3 points)

   Possible responses include:
   - **Barrier methods alone**
   - **Fertility awareness–based methods**
   - **Lactational amenorrhea**
   - **Coitus interruptus**

10. Informed choice means (check all answers that are true): (2 points)

   ☑ **The client has been given full information.**

   ☐ The client cannot leave the service site without choosing a family planning method.

   ☑ **The provider helps the client to make a decision.**

   ☐ Family members motivate the client to choose a particular family planning method.

11. What is empathy? (1 point)

   Putting yourself in the client's position and understanding her point of view as if it were your own.

12. Give two examples of how to create a more comfortable environment for counseling. (2 points)

Possible responses include:

- **Make sure the client is ready to talk.**
- **Sit or stand on the same level as the client.**
- **Speak in a low voice.**
- **Shut the door.**
- **Speak in the client's mother tongue or local language.**
- **Ensure confidentiality.**

13. A woman arrives at your site with an obstetric fistula that occurred following obstructed labor. Using simple language, explain to the client what is happening in her body. (2 points)

An obstetric fistula develops when blood supply to the tissues of the vagina and the bladder (and/or rectum) is cut off during prolonged obstructed labor. The tissues die and a hole forms through which urine and/or feces pass uncontrollably.

14. Explain how beliefs can influence the care that providers give. Give one concrete example of a belief, value, or judgment about obstetric fistula and how this could affect care. (2 points)

Our beliefs shape our attitudes or the way that we think about and act toward particular people or ideas.

Possible examples:

- **If a provider believes that all women with obstetric fistula will never again have sexual relations, the provider might not adequately counsel the client about the need for sexual abstinence or about family planning methods.**
- **If a provider believes that a woman with obstetric fistula has brought the problem on herself by being negligent about her health care, the provider might have difficulty providing empathetic care.**

15. List three important issues to address when counseling the obstetric fistula client and her partner together. (3 points)

Possible responses include:

- **Dispel any myths about why the client got a fistula.**
- **Cover issues related to postoperative care, including the need for sexual abstinence for at least three months, family planning, and timing/need for follow-up visits.**
- **Discuss how to support the client's reintegration into her family and her community.**
- **Discuss how to prevent obstetric fistula, including the need for early and regular medical care during pregnancy and childbirth.**

16. List three issues that might be better explored in a counseling session with client alone, rather than with her and her partner together. (3 points)

    Possible responses include:

    - **Sexuality issues**
    - **Sexually transmitted infections**
    - **Other sexual partners**
    - **How best to support the client emotionally**
    - **How best to help the client regain her sense of self**

Points Total: 35 Points needed for 80%: 28

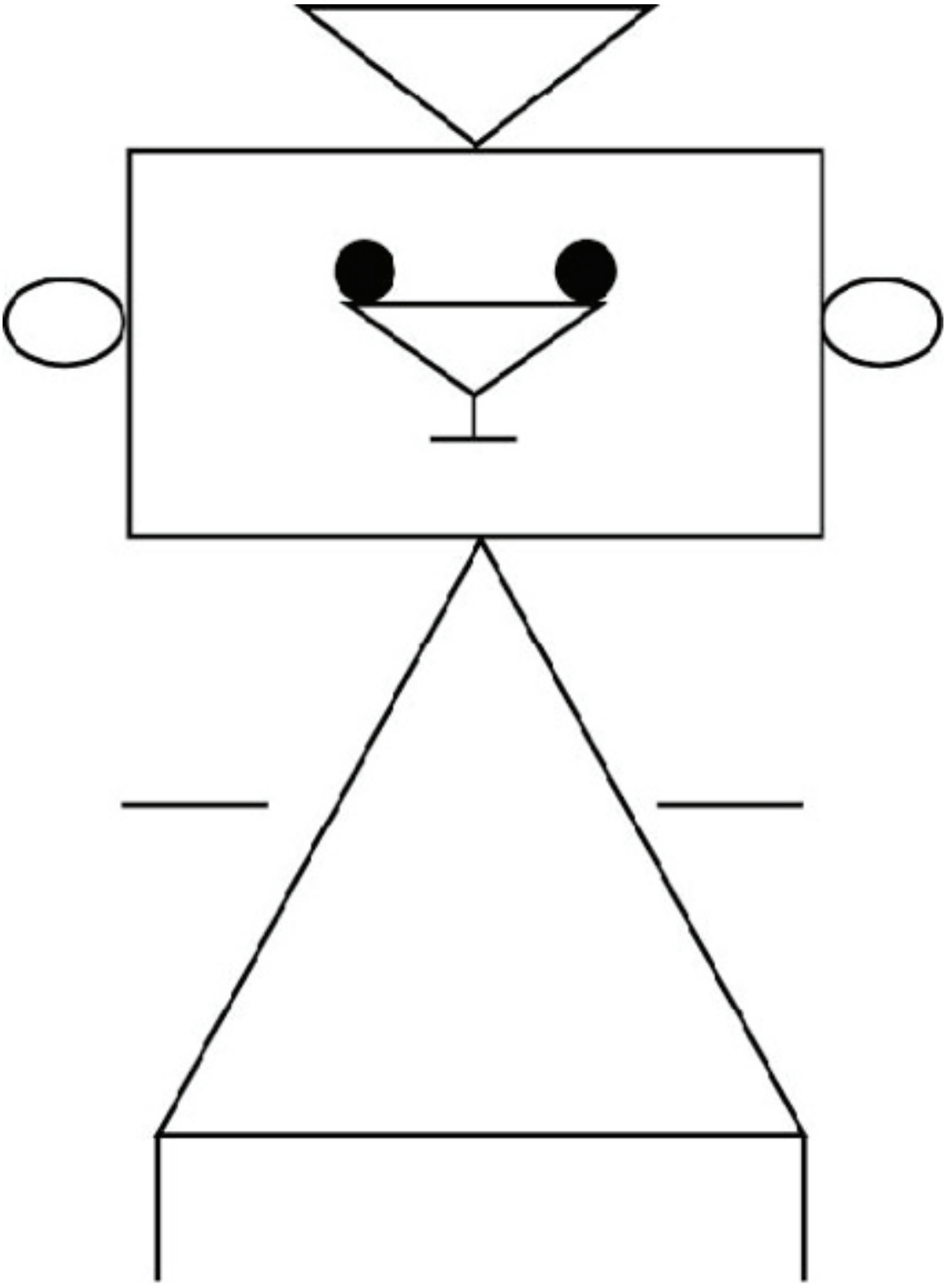
Appendix D

Transparencies and Activity Materials

You may wish to make transparencies and/or photocopies of the following items prior to the training. If an overhead projector is not available, prepare flipcharts to display during the training.

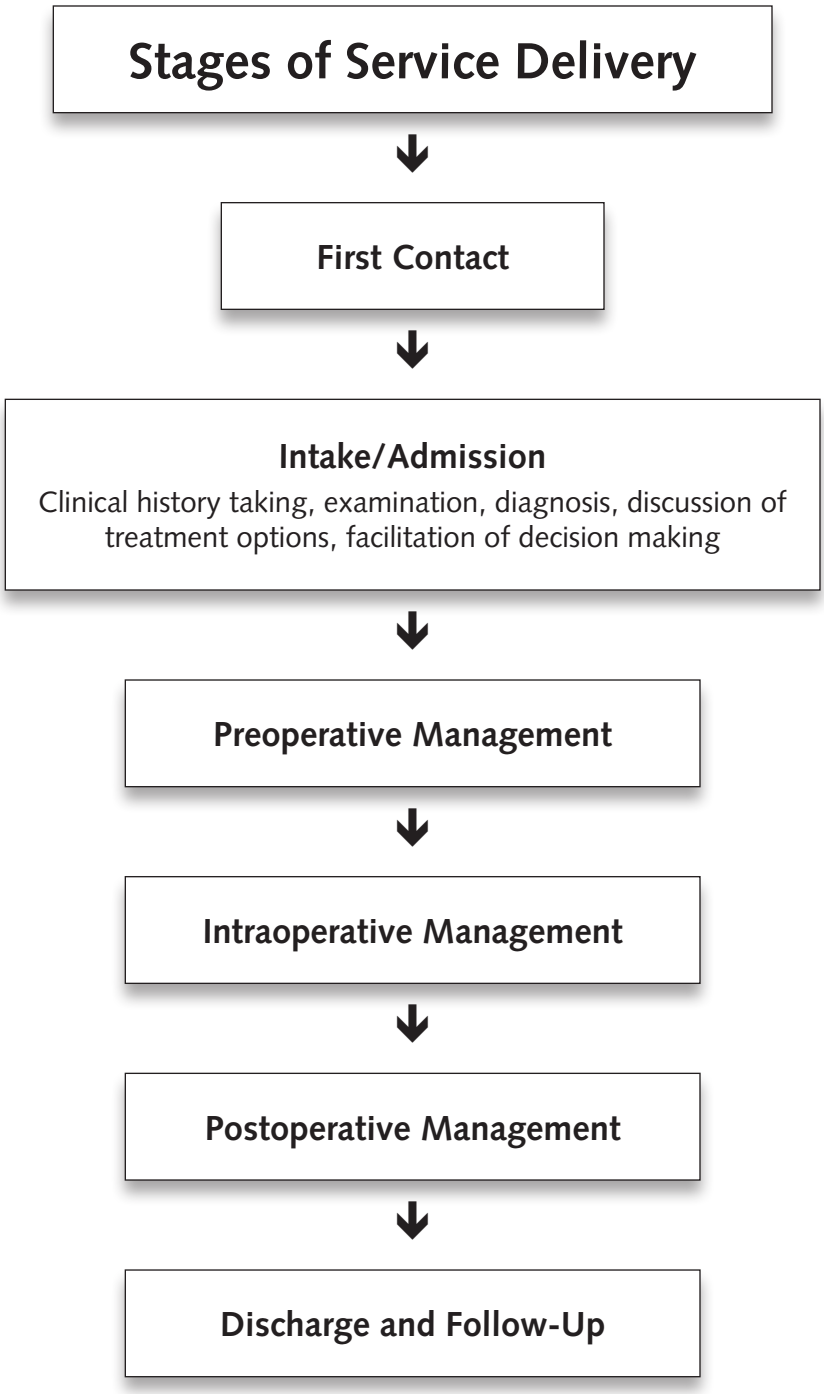
Transparency 5-A

Sample Diagram



Transparency 6-A

Sample "Map" for Case-Study Client Walk-Through of Services



Adapted from: The ACQUIRE Project and EngenderHealth. 2005. *Report of fistula counseling experts' meeting: March 29 & 30, 2005, Kampala, Uganda.* New York.

Transparency 8-A

Sample Counseling Learning Guide: Preoperative and Immediate Postoperative Periods	
Information to Be Provided	**Responses/Data Collected**
Preparation	
Greet the person respectfully and with kindness and introduce yourself.	
Offer a seat.	
Ensure necessary privacy.	
Assess whether counseling is appropriate at this time. (If it is not, arrange for counseling at another time.)	
Ensure confidentiality of client information when providing information or asking for information.	
Counseling	
Based on the client's condition, provide information about the following, as appropriate and only after assessing the support person's ability or capacity to give or receive information:	
• Client's needs	
• Ways to support the client	
• Hospital routines and procedures	
• Client social support groups within facility	
• If condition not treatable, information on community support networks and ways to support the client as she goes about her life	
Explore the family member's needs and feelings.	
Explore attitudes, myths, misconceptions, or religious beliefs.	
Address any fears or concerns, as necessary.	
Ask if there are any questions, and answer appropriately.	
Share success stories, as appropriate.	
Provide information on available client support groups within the facility.	

Transparency 8-B

Sample Counseling Learning Guide for the Discharge/Follow-Up Periods

Information to Be Provided	Responses/Data Collected
Preparation	
Greet the person respectfully and with kindness and introduce yourself.	
Offer a seat.	
Ensure necessary privacy.	
Assess whether counseling is appropriate at this time. (If it is not, arrange for counseling at another time.)	
Ensure confidentiality of client information when providing information or asking for information.	
Counseling: General	
Based on the client's condition, provide information about the following, as appropriate and only after assessing the support person's ability or capacity to give or receive information:	
Possible side effects, risks, and warning signs, and the need to develop a plan in case of complications	
The client's needs and ways to support the client	
How the client needs to take care of herself at home, including:	
• Necessary period of abstinence	
• Delay of pregnancy and available contraceptive methods, as appropriate	
• Plan for follow-up visits and importance of follow-up	
Reproductive tract infections and sexually transmitted infections, including HIV	
Sexuality after surgical repair, as appropriate	
Links to community organizations, where available	
Income-generating activities and educational opportunities, if possible and available	
Explore the family member's needs and feelings.	
Explore attitudes, myths, misconceptions, or religious beliefs.	
Address fears and concerns, as necessary.	
Ask if the family member has questions, and answer these appropriately.	
Share success stories, as appropriate.	
Provide links to community organizations, where available.	
Discuss income-generating activities and educational opportunities, if possible and available.	

Appendix E

Sample Case Studies

The following case studies can be used as examples for Session 3, Part A. In addition, if there is not sufficient time to develop original case studies, the participants may adapt some of these cases to fit their local circumstances. Some of the case studies below are the actual stories of women with fistulas; in each of these cases, we provide information on the source of the story. The remaining stories are fictional.

Case Study 1: Tigest, age 16

Tigest was married at age 12. She is not literate and has never been to school. At age 14, Tigest gave birth to a stillborn baby girl after four days of laboring at home, assisted by a traditional birth attendant (TBA). When she began leaking urine after the birth, the TBA told her that it was most likely because she had received a curse from God.

Tigest's husband finds her dirty, and although he does not divorce her, he does not let her stay in the house. Her family will not take her back, and Tigest has no income and depends on her husband for her livelihood, so she must stay with her husband, even though he will not allow her to reside in the house.

Tigest hears that doctors in a hospital in the capital city might be able to help heal her. Her husband and family tell her that no doctors can help her because God obviously did not hear and reply to her prayers during labor. So she decides to take a risk and run away from her husband and get to the capital city by any means. At times, she has to prostitute herself to get money.

When she arrives at the hospital, she is told that they have funds to help her get surgery that they believe will be relatively uncomplicated. Unfortunately, complications occur during surgery, so the operation is not successful. To make matters worse, during screening, it is discovered that Tigest is HIV-positive. Tigest is living in the hospital compound until she can make another plan.

Case Study 2: Mariam, age 18

Mariam lives in a very remote village. She is not literate and has never been to school. When she gave birth at age 16, the traditional birth attendant (TBA) assisted her. Her labor was very long, and on the second day, the TBA said they needed to get her to a hospital. Mariam's husband was away and she had no money, and no one wanted to take responsibility for taking Mariam to the hospital. On the third day, Mariam finally gave birth to a stillborn child.

After she gave birth, Mariam noticed that she was leaking urine, but she was too ashamed to mention this to anyone, especially after the shame of giving birth to a stillborn child. When her husband came back, he noticed the smell and threw her out of the house. Soon after, he took a second wife. Mariam's parents could not afford to have her in the house, so she had to resort to begging for food.

A mobile health team came through Mariam's village and talked about fistula and the possibility of repair. Mariam made her way to the fistula hospital, where she had a successful repair. She does not feel she has any place to go home to and has made the hospital her new home.

Case Study 3: Maimouna, age 26

Maimouna is 26 and has given birth six times, but she has only three living children. She is the second wife to her husband, who loves and dotes on her. Maimouna's sixth child was stillborn, and she developed a fistula and began leaking urine after that birth. Her husband is distressed by Maimouna's physical problems and is anxious to assist his wife, but he has been told that there is nothing that can be done to help her. Maimouna has a sixth grade education and sews clothing for extra income.

Maimouna hears that her fistula might be reparable, and she and her husband go to the hospital in the capital city. She undergoes the surgery and has a successful repair. Maimouna would like to have more children.

Case Study 4: Aberesh, age 22

At the age of 18, Aberesh was married to an older man in a remote rural area. Aberesh has never gone to school and does not know how to read and write. She became pregnant immediately after getting married. The pregnancy was difficult. Labor was obstructed, and Aberesh was unable to deliver. On the third day of labor, her relatives decided to get help. They sold a goat and paid men to carry Aberesh on a stretcher for six hours to the nearest hospital. By the time she arrived, it was too late to save the baby; her son was stillborn.

Aberesh was so weak and exhausted from the ordeal that she could not get out of bed. It took another four weeks before she could walk by herself again. Two days after giving birth, she began to leak urine from a fistula. Nothing would stop the flow. Her husband sent her back to her mother's house to get better.

A doctor in the hospital told her relatives about the possibility for repair at a hospital in the capital city. Once again, her family rallied to support her and raised money for bus fare to the capital city. At the fistula hospital, her repair surgery was uncomplicated, and she recovered completely. She plans to return to her parents' home and hopes that she can get married and have children.

Adapted from: *A personal story provided by the Addis Ababa Fistula Hospital*

Case Study 5: Asha, age 20

Asha and her husband lived in a small village and were very poor. Her husband worked as a guard at the village government office and earned a meager salary. Asha went to school until she was 12 years old, and she can read and write. Asha's first pregnancy was not difficult, and she delivered her first baby at home with no problems. When she was ready to deliver her second child, she experienced a very difficult labor and had to be taken to a hospital. Because there was no money to get her to the hospital, her husband took out two loans: One for $6 to pay for a wheelbarrow pulled by a cow to carry her to a main road, and another for $60 for a car to drive them from the main road to the hospital.

Although Asha was able to get a cesarean operation, her baby died from the prolonged labor, and she developed a fistula. The cesarean operation cost $40, a fee that they could not afford, so Asha's husband took a loan from the village government. The loan required him to work without a salary until his debt is repaid. This left the family without a source of income.

In addition, Asha was too weak to make the six-hour round trip to the nearest well, and she needed extra water to wash herself and her clothes because of the constantly leaking urine. Thus, along with the mounting debt, Asha's husband had to pay 10 cents a day to someone willing to collect water from the well and bring it to Asha.

Keeping up with loan payments was difficult, so the family sold a plot of land for $20 and one of their five cows. Still, this only paid off a small portion of their debts. Along with the financial strains, Asha continued to suffer because of her fistula. Friends collected some money to help the family and pay for Asha's fistula repair. The repair surgery was successful, but the family remains deeply in debt.

Adapted from: *Faces of Dignity, © Women's Dignity Project, 2003.*

Case Study 6: Pendo, age 46

Pendo has lived with a fistula for more than 30 years. As a young girl, she attended school until she was 12 years old, and her father forced her to marry. According to local custom, Pendo lived with her husband's parents until age 14; at that point, she had her first menses and moved into her husband's home.

Pendo worked hard during her first pregnancy, collecting firewood and water, and doing all of the other domestic chores. When her baby was born, her labor was difficult, painful, and long. After being in labor for three days at home, her family finally took her to a hospital 20 kilometers away. The doctors delivered the baby by forceps.

The baby survived, but Pendo developed a fistula as a result of the prolonged labor. She tried several times to have the fistula repaired, but each time she went to the hospital, there was no surgeon available to perform the operation.

Pendo's brother said the problem could not be cured and told her that she should give up on trying to get treatment. Pendo's husband was advised to abandon her and marry another woman, but he ignored that advice and remained very supportive and loving. After Pendo got the fistula, she went on to have 11 more children, all of whom treated her with respect and kindness. The sons and daughters helped with the household chores and washed Pendo's urine-soaked clothes.

She continued to work and support her family throughout all those years, but she faced significant social challenges. Ashamed of leaking urine uncontrollably, Pendo avoided situations where people might find out about her problem. Whenever she came across someone walking along the road, she would cross to the other side so that they could not smell the odor.

When Pendo learned that her fistula could be cured, she immediately went for repair. The surgery was successful, and Pendo finally stopped leaking. When she was fully healed and ready to return to her family, her providers reminded her that she must wait three months after the surgery to resume sexual relations. Pendo happily told the providers, "Three months of waiting, after 32 years of leaking, is nothing!"

Adapted from: *Faces of Dignity, © Women's Dignity Project, 2003.*

Case Study 7: Khady, age 21

Khady was married at age 19, uses family planning for several years, and chose to become pregnant at age 21. Her husband is in the military and when Khady is five months pregnant, he was posted in another town., However, he left money for Khady's antenatal and labor and delivery costs. Khady, who had studied up until high school, asked that her husband ensure that she could give birth in the health center. Khady was living with her mother-in-law while her husband was away, and her husband told his mother to take Khady to the health center as soon as she went into labor.

When Khady went into labor, her mother-in-law called the traditional birth attendant, and all three of them went to the health center.. The midwife at the health center told Khady that her birth canal was constricted because she had not had sex for so long, and so she would need an episiotomy. During the birth, the episiotomy became extended and the midwife had trouble repairing it. The midwife told Khady to keep her legs crossed to facilitate healing.

When Khady came home, she noticed that she sometimes passed flatus through her vagina, and once she believed that diarrhea was also coming from her vagina. The midwife told her that she needed to be patient and wait for it to heal on its own. Khady decided to write to her husband, and he sent her money to go to the capital city for treatment. Khady had a successful repair of her fistula.

Case Study 8: Neema, age 17

When Neema was 15 years old, a man in her village abducted her, locked her in his sister's house, and raped her repeatedly for three days. According to Neema's culture, since she spent the night alone with the man, she had to marry him. Neema's father and brother gave her to the man in exchange for six cows.

The couple moved to the city and worked selling vegetables. When Neema got pregnant she sought antenatal care and worked long into her pregnancy so that she could afford a hospital delivery. The day she went into labor, her husband's family waited for nearly 24 hours before taking her to a hospital. Neema had to try two different hospitals, and she waited two days before she finally received a cesarean operation. Her baby did not survive, and soon after her operation she discovered that she was leaking. Because neither her husband nor his family visited her, Neema spent two months alone, recovering at the hospital. The relatives of other clients were kind and gave her food and water. When she finally went home, her husband said that he no longer needed her; he now had a new wife who did not leak urine. Although he had treated her badly, Neema did not leave because she had nowhere to go.

Neema's brother eventually helped her obtain a fistula repair. The operation was only partially successful, leaving her unable to pass urine except through a catheter. Neema's husband threw her out of the house.

Adapted from: *Faces of Dignity, © Women's Dignity Project, 2003.*

Case Study 9: Abeba, age 18

Abeba studied in school until seventh grade. She got married when she was 15 to a man whom she met for the first time on her wedding day. Although she was sad not to be able to continue her education, she was happy with her husband.

She got pregnant one year later. Her pregnancy was fine. Her labor started at 3:00 in the afternoon, and her husband and mother were with her. A traditional birth attendant told her to go to the hospital, where they performed a caesarean operation, but the baby died. Abeba noticed that she was leaking urine after the birth, but she was told by the doctor that it would get better on its own.

She returned to her village and the leaking got worse. Two months later, her husband married another woman, and Abeba moved in with her mother. Someone in the village told her she could get an operation if she went to the capital city. Friends and family helped her get the money to go for the surgery. Her surgery was successful.

When asked about her future, she says, "When I am cured, I want to go back home and continue my education. I want to study and I want to become a doctor like the doctors here, so that I can help girls like me who have this problem. When I go back to my village, I will tell other women to go immediately to a hospital so that they won't have a problem with their labor. Most people do not know that a hospital can help them, but if they knew, they would go."

Adapted from: *A personal story provided by the Addis Ababa Fistula Hospital*

Case Study 10: Simenye, age 19

Simenye was living with her cousin in a refugee camp after her parents died. Her cousin chose a husband for her, and Simenye was married at age 18. Soon after the wedding, she got pregnant.

During the labor, her cousin and her husband and some neighbor women were with her. She was in labor for four days, and on the fourth day the baby came, but it was dead. When the baby died, her husband left her. Simenye believes the baby died because she had a sickness when she was pregnant that she caught from the wind.

After the birth, Simenye began leaking urine. People told Simenye that her body was wounded and advised her to go to a hospital in the capital city where she could get help. She was told that the operation she needed was simple and that there was a high likelihood of full success.

When asked what she would like to do in the future, she says, "When I am cured, if my cousin will let me, I want to stay here and work in someone's house. Otherwise, if I go back home to my cousin, I will go to school. I would like to go to school."

Adapted from: *A personal story provided by the Addis Ababa Fistula Hospital*

Case Study 11: Naneye, age 14

Naneye got married at age 12 and got pregnant two years later. Her pregnancy was fine. She was not sick until the labor. Her family and husband were with her during the labor. She labored for four days, and on the fourth day she was taken to a health center. At the health center, she delivered a dead baby.

Soon after the delivery, she noticed that she was leaking urine, and the providers at the health center referred her immediately to a specialized hospital in the capital city. Her husband got the money together and took her to the hospital, where the doctors performed a successful surgery on her fistula. Ever since the

surgery, Naneye's husband visits her regularly and is eagerly waiting for her to come home. They hope to have children sometime soon.

Adapted from: *A personal story provided by the Addis Ababa Fistula Hospital*

Case Study 12: Mekebe, age 18

Mekebe is a fistula client who sought care at the Addis Ababa Fistula Hospital in Ethiopia. She described her experience in the following way:

> I got married three years ago. I got pregnant one year ago. When I was six months pregnant, I left my husband's house and went to my mother's house so that I could have my baby at home with my mother. When I started my labor, my mother and my sisters were there with me.
>
> I was in labor for three days, and it was very difficult. My stomach was hurting me so much. After the third day, my mother took me to the hospital where the doctor took out the dead baby. They took me back to my mother's house, and I was very sick. I didn't walk for ten days, and I was leaking urine. My husband was not there with me during my sickness, so three months after the baby died, I left him.
>
> The doctor at the hospital gave me a referral paper and told me to go to the capital city. I took a bus all day to get there. I was very sick, so they gave me medicine for three months before I could have my operation. I was scared of the operation at the beginning, but when I knew that there was no pain, it was okay. After the operation, I stayed in bed for a long time to recover.
>
> If it is possible, I want to get married again and have a baby. I will go back to my mother's house and I will work in my village. I look forward to going home and seeing my friends again without this sickness.

Adapted from: *A personal story provided by the Addis Ababa Fistula Hospital*

Case Study 13: Safina, age 21

Safina has been married for six years. Two years after her marriage, she became pregnant. During her pregnancy, she did not receive any antenatal checkups. When her labor pain started, her mother-in-law called the traditional birth attendant (TBA) to their home. The TBA gave Safina some injections for her delivery, but all failed. At last, Safina's mother-in-law decided to take her to the nearby hospital. Her mother-in-law borrowed some money from her neighbors and found transport. After three days and three nights, Safina was transferred to a health center, accompanied by one TBA. Because there was no opportunity to perform a cesarean operation, she was taken to a TBA's home, and she stayed there for another two days. After that, she was shifted to a hospital, and a dead baby was delivered by a cesarean operation.

After recovery, she found that she had developed incontinence of urine and stool. The providers at the health center informed her about how her condition could be treated. Three months after her cesarean operation, she underwent surgery for her incontinence at a large teaching hospital, and she was asked to return after three months for a second operation. The surgery for the rectovaginal fistula was successful, but

she could not return for her second surgery because of financial constraints. Now, after three years, she has returned for treatment of the vesicovaginal fistula.

Safina said, "It is difficult to continue work and do other things. I have to always wear heavy cloths. I did not have any urge to pass stool before the operation, and now I have no urge to pass urine. My menstruation has stopped since my pregnancy. I have white discharge and genital blisters and itching that are all very disturbing. I have to continue doing my work, and it causes increased dribbling of urine.

"Nobody wants to stay with me due to the smell of urine. Even my husband left me after the incident and never came back. We are very poor. Once I had a job and I worked, but now nobody is taking me as a maid due to my problems. We have no money. My father has sold his cow for my treatment."

Adapted from: *EngenderHealth/Bangladesh. Bangladesh onsite training curriculum for counseling for obstetric fistula clients. Unpublished curriculum.*

Appendix F

Glossary

Amenorrhea: absence of menstrual bleeding.

Attitude: the way that we think about and act toward particular people or ideas.

Belief: something that an individual feels to be true or accurate.

Closed-ended questions: questions that call for a brief, exact reply, such as "yes," "no," or a number.

Confidentiality: not discussing the client's personal information with her partner, with the family member(s) accompanying her, or with staff members who are not directly involved in her treatment (except where required in a life-threatening emergency).

Counseling: the process of helping a client confirm or make informed and voluntary decisions about her individual care.

Dignity: the ability to feel self-worth and honor, regardless of one's physical circumstances.

Foot drop: an extended position of the foot caused by paralysis of the flexor muscles of the leg; in women, it can be caused by obstructed labor.

Gender: a set of qualities and behaviors expected by society from a woman or a man.

Informed choice: a voluntary, well-considered decision that an individual makes on the basis of options, information, and understanding.

Informed consent: communication between a client and provider that confirms the client has made an informed and voluntary choice to use or receive a medical method or procedure.

Obstetric fistula: an abnormal passage or opening between the genital tract and the urinary or intestinal tract; results in the uncontrolled passage of urine or feces from the bladder or rectum into the vagina, and is usually caused by an injury that occurred during delivery, most frequently by prolonged labor.

Obstructed labor: occurs when the fetus will not fit through the mother's pelvis, when the fetus is not positioned correctly for delivery (malpresentation), or when uterine contractions are ineffective in delivery.

One-way communication: communication in which only one person is actively talking, giving no chance to the other person to ask questions or express feelings and opinions.

Open-ended questions: questions that explore opinions and feelings and usually require longer responses.

Privacy: having the power to control information about oneself; being free from the observation, intrusion, or attention of others; and being apart from other people and not seen, heard, or disturbed by them.

Recto-vaginal fistula (RVF): a passage/opening between the rectum and the vagina, leading to passage of flatus or stool through the vagina, frequent vaginal infections, or a foul-smelling vaginal discharge, or frank stool being passed out of the vagina.

Sexuality: encompasses the sexual knowledge, beliefs, attitudes, values, and behaviors of individuals; deals with the anatomy, physiology, and biochemistry of the sexual response system; roles, identity, and personality; and individual thoughts, feelings, behaviors, and relationships.

Traumatic gynecological fistula: an abnormal passage or opening between the genital tract and the urinary or intestinal tract, often caused by sexual violence.

Two-way communication: communication in which both persons are active in sharing information and opinions and in clarifying information with questions.

Ureterovaginal fistula: a passage or opening between the distal ureter and the vagina. The urine from the ureter bypasses the bladder and flows into the vagina. This also results in total or continuous incontinence.

Urethrovaginal fistula: a passage or opening between the urethra and the vagina. The urine from the bladder freely flows into the vagina, leading to total or continuous incontinence.

Value: a belief that is important to an individual. Values can be influenced by religion, education, culture, and personal experiences.

Vesicouterine fistula: a rare complication of vaginal birth after cesarean section. It is passage/opening between the uterus and the urinary bladder where urine from the bladder flows freely into the vagina, leading to total or continuous incontinence.

Vesicovaginal fistula (VVF): a passage or opening between the urinary bladder and the vagina. The urine from the bladder freely flows into the vagina, leading to total or continuous incontinence.

Appendix G

Additional Resources for Trainers

EngenderHealth Counseling Materials

Choices in family planning: Informed and voluntary decision making. 2003.

Comprehensive counseling for reproductive health: An integrated curriculum. 2003.

Counseling and communicating with men. 2003.

Counseling the postabortion client: A training curriculum. 2003.

Integration of HIV/STI prevention, sexuality, and dual protection in family planning counseling: A training manual. 2002.

Youth-friendly services: A manual for service providers. 2002.

Other Counseling Materials

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Appendix H

Sample Client-Education Material

This material can be used as a guide for developing local-language client-education materials. Review it before using it, and modify the content slightly, as needed, to fit your local setting.

How do I prevent future occurrences of fistula?

I discourage early pregnancy. A woman of 15 years has a risk of suffering pregnancy complications many times higher than a woman of 20 years. Younger mothers are at a greater risk of obstructed labor.1

I use family planning. This is one way of delaying early pregnancy and avoiding poorly spaced pregnancies. There are a variety of methods for contraception that are adaptable to any situation: male or female condom, contraceptive pill, injection, implants, and so on.

I attend regular antenatal visits for future pregnancies. Risks for pregnancy complications are detectable during antenatal consultations. It is also important for me to attend consultations after delivery to decrease the risk of postpartum complications.

I ascertain potential risks for future pregnancies. Women with a higher risk of developing a fistula include those who are younger than 18 years old; those having their first pregnancy; women of small stature (less than 150 cm tall) and/or with a narrow pelvis; women who have had a large number of pregnancies over a short period of time; and women who have had fistula repair previously and were deliver vaginally, without caesarian section.

I ensure that I deliver with assistance of skilled health provider for future pregnancies. Having a skilled attendant at the birth improves my chances of survival and the survival of my baby. It also facilitates the possibility of addressing complications that may arise and decreases the risk of developing complications.

I make sure that I have an evacuation plan. My family should be sensitized to the costs associated with transport to a referral center and should minimize any delay in deciding for my going or taking me to that center.

Action Steps to Reduce Occurrence of Fistula:

- I sensitize my household to the dangers of early pregnancy.
- I attend regular antenatal and postnatal visits.
- I talk with my family to promote an assisted delivery.
- I do not allow the sun to rise or set twice if I am in labor.

- I inform my community that fistula is a treatable condition.
- I help other women with fistula identify a treatment center.
- I discuss with my family/husband the importance of long-term medical follow-up.
- During future pregnancies, I go to a medical center at least three months before the delivery.

Adapted from: Réseau pour l'Eradication des Fistules (REF). 2005. *Eradiquons les fistules au Niger*. Niamey ; and International Sexual and Reproductive Rights Coalition. [No date.] *Fact Sheet: Maternal health: Implications for children and adolescents*. New York. Retrieved from http://www.reproductiverights.org/pdf/pub_fac_adoles_maternalhealth.pdf/.

Appendix I

Cross-Cutting Issues

Fistula is a problem that no one likes to talk about. The women themselves frequently feel such shame at their constant wetness and smell that they hide themselves away. Or, worse still, they are forced to live in isolation from their communities, even their families, because of the stigma and misunderstandings associated with the condition.

"Sharing the Burden; Uganda Women Speak about obstetric fistula (2007)" a study carried out in Uganda by EngenderHealth and Women Dignity Project, found that husbands, mothers-in-laws and mothers had influence on health seeking behavior of pregnant women since fewer than half (25–45%) of the women interviewed decided to go for ANC by themselves. There is therefore need for involving men as partners (MAP) in fertility, pregnancy and delivery issues of their wives.

Fistula Clients have a right to safe services, which require skilled providers, attention to infection prevention, and appropriate and effective medical practices. Safe services also mean proper use of service-delivery guidelines, quality-assurance mechanisms within the facility, counseling and instructions for clients, and recognition and management of complications related to medical and surgical procedures. In addition, fistula clients have the right to be treated with respect, dignity, and consideration.

Whole-Site Training

Whole-site training (WST) is a training approach that focuses on meeting the learning needs of a site by linking supervision and training, emphasizing teamwork and sustainability, and applying a range of training strategies. The types of training include orientations to new services or concepts, knowledge updates, and skills training. The locations for training can be on the job, onsite, and at regional or central training sites. The emphasis is on conducting the training at or as close to the site level as possible. WST includes "in-reach" within a facility (sharing of knowledge learned through training with others at the site, onsite orientations about services provided, linkages between departments, and a referral system within a facility, and adequate signs) to ensure that clients do not miss opportunities to access information and services for all their reproductive health needs when they come to the site.

The Six Elements of the Whole-Site Training Approach

1. *Linking the supervisory and training systems* to involve both internal and external supervisors in assessing training needs and in planning, developing, and conducting the training. External supervisors assist the site staff in accessing training resources outside the site. The WST approach encourages supervisors to provide follow-up and support to trainees, regardless of where they were trained. Supervisors also orient staff members who do not participate in off-site training in order to encourage them to support the returning trainees as they apply their new knowledge and skills. WST enables mentoring between

supervisors and staff and among staff. Supervisors ensure that the site has appropriate supplies and equipment for practicing new skills and providing new services. The training and supervisory systems complement each other, which leads to sustained improvement.

2. *Assessing site training needs and planning to meet them*. Assessment begins at the site level and information can be gathered through COPE® (a process and set of tools for improving quality in health services), medical monitoring, or other processes. Site staff know the facility best and can best identify gaps in the quality of care, plan, prioritize, and take action as a team to make training fit their needs. Centralized training remains an important element of the WST for meeting particular needs—for example, when introducing a new contraceptive method or when particular skills are needed.

3. *Focusing on teams, not on individuals*. Working as a team, staff are better able to understand the role and value of each staff member in providing quality services, and they identify the training needs that fulfill their team responsibilities.

4. *Tailoring the level of training to the needs of different employees*. The WST approach is more flexible than centralized training because it includes different types of training. The site decides what level of training is needed for each level of service providers: skills training, service orientation, or updates.

5. *Expanding the locales where training occurs*. Skills training, updates, and orientation can all be done onsite, allowing the transfer of knowledge and skills to a greater number of staff. Training can be adjusted more easily to meet the specific needs of the site and its staff.

6. *Building sustainable capacity*. Trained and certified (as required) individuals become part of the local pool of skilled individuals who train others. The overall capacity is built as skills are transferred. Information sharing and training become part of daily work, thus promoting sustainability. Problem solving becomes part of performance improvement.

Adapted from: Kaniauskene, A., Mielke, E., and Beattie, K. Improving reproductive health services through whole-site training. Adapted from the presentation at the Global Health Council 28th Annual Conference, Washington, D.C., May 29–June 1, 2001. Updated October 2003.

For more information on whole-site training, see:

EngenderHealth. 1998. Whole-site training: EngenderHealth's approach to training. Working Paper No. 11. Retrieved from http://www.engenderhealth.org/pubs/workpap/wp11/wp_11.html

Quality Improvement

Quality Improvement (QI) is the concerted and continuous effort to do things better until they are done right the first time, every time. The aim is to move services from "actual practice" to "desired practice."

QI is based on six key principles:

1. *Staff involvement and ownership:* All levels of staff should be involved in the QI process.

2. *Client mindset:* The needs and expectations of clients should be met.

3. *Focus on systems and processes:* Poor quality is often a function of a weak system and processes, rather than the fault of individuals.

4. *Cost consciousness and efficiency:* QI will eliminate the costs of poor quality (e.g., rework, waste, and, in this case, death or disability).

5. *Continuous learning development and capacity building:* Staff need skills to carry out the QI process and provide quality services; the team leader facilitates the work of the team and the development of those skills. Because the QI tools are based on international standards, staff also learn standards as they carry out the QI process.

6. *Ongoing QI:* There will always be opportunities to improve what the team does; to have a sustained positive impact on services, QI must be a continuous process.

The QI process is designed for use by a team on a regular basis so that they can assess and adjust systems and practices in a constructive way. This process begins with a foundation-laying step and continues with four steps that are repeated on an ongoing basis. The foundation step is a workshop for the team to create a vision of the quality of services they can provide. The four ongoing steps include:

- **Gather and analyze information:** Staff identify areas of their work that need improvement, examine root causes, and recommend solutions.
- **Develop an action plan:** Staff identify what they need to make improvements in the areas they have identified.
- **Implement solutions:** Staff implement chosen solutions, with support and coordination from their team leader.
- **Review and evaluate progress:** Staff take time to recognize progress and celebrate successes, identify obstacles to further progress, and make new recommendations. This is also the time to start the next round of information gathering and analysis.

Adapted from: EngenderHealth and AMDD. *Quality improvement for emergency obstetric care: Leadership manual and toolbook*. Retrieved from http://www.engenderhealth.org/res/offc/mac/emoc/index.html#qi-emoc

For more information on Quality Improvement, see:

EngenderHealth. *COPE® handbook: A process for improving quality in health services*. Revised edition. Retrieved from http://www.engenderhealth.org/res/offc/qi/cope/handbook/index.html

EngenderHealth. *COPE® for maternal health services: A process and tools for improving the quality of maternal health services*. Retrieved from http://www.engenderhealth.org/res/offc/qi/cope/toolbook/maternal.html

EngenderHealth and AMDD. *Quality improvement for emergency obstetric care: Leadership manual and toolbook*. Available at: http://www.engenderhealth.org/res/offc/mac/emoc/index.html#qi-emoc

Infection Prevention

Without the proper precautions, your health care facility can cause the spread of infections and diseases. When providing health services, it is essential to prevent the transmission of infections at all times.

Although we do not often think about it, health care facilities are ideal settings for the transmission of disease because:

- Invasive procedures, which have the potential to introduce microorganisms into parts of the body where they can cause infections, are performed routinely.
- Service providers and other staff are constantly exposed to potentially infectious materials as part of their work.
- Many of the people seeking health care services are already sick and may be more susceptible to infections.
- Some of the people seeking services have infections that can be transmitted to others.
- Services are sometimes provided to many clients in a limited physical space, often during a short period of time.

With appropriate infection prevention practices, you can:

- Prevent postprocedure infection, including surgical-site infections and pelvic inflammatory disease
- Provide high-quality, safe services
- Prevent infections among service providers and other staff
- Protect the community from infections that originate in health care facilities
- Prevent the spread of antibiotic resistant microorganisms.
- Lower the costs of health services, since prevention is cheaper than treatment

The best way to prevent infections at a health care facility is by following standard precautions. Standard precautions are a set of recommendations designed to help minimize clients' and staff members' exposure to infectious materials. They include the following measures:

- Wash your hands.
- Wear gloves.
- Wear eye protection or face shields.
- Wear gowns.
- Prevent injuries with sharps.
- Correctly process instruments and client-care equipment.
- Maintain correct environmental cleanliness and waste-disposal practices.
- Handle, transport, and process used/soiled linens correctly.

Standard precautions should be followed with every client regardless of whether or not you think the client might have an infection because it is not always possible to tell who is infected with viruses such as HIV and hepatitis. Often the infected persons themselves do not know that they are infected. It is safer to act as if every client is infected than to apply standard precautions to some clients and not others.

Adapted from: EngenderHealth. 2011. *Infection prevention: A reference booklet for health care providers, 2nd ed.* Retrieved from http://www.engenderhealth.org/res/offc/safety/ip-ref/index.html

For more information on Infection Prevention, see:

EngenderHealth, 2003. *Infection prevention practices in emergency obstetric care*. Retrieved from http://www.engenderhealth.org/res/offc/safety/ip-emoc/index.html

EngenderHealth, 2011. *Infection prevention: A reference booklet for health care providers 2nd edition*. Retrieved from http://www.engenderhealth.org/res/offc/safety/ip-ref/index.html

EngenderHealth. [No date given]. Retrieved from http://www.engenderhealth.org/ip/index.html.

Men As Partners®/Male Involvement

While women receive the bulk of reproductive health education, including family planning information and information about how and where to give birth, gender dynamics can render women powerless to make decisions. Men often hold decision-making power in matters as basic as sexual relations and when and whether to have a child or even seek health care. Reproductive health programs must recognize the importance of partnership between women and men reach out to men with services and education that enable them to share in the responsibility for reproductive health.

EngenderHealth's Men As Partners® program uses the following three related elements of constructive male involvement to:

- Improve men's awareness such that it enhances men's support for their partners' sexual and reproductive health
- Reduce social barriers that limit men's access to health services
- Challenge the current gender order so that men can be allies or act as agents of change in the improvement of their own health and the health of the women and children who are often placed at risk by gender roles

These fundamental principles can be applied in both service delivery and community settings.

Men are generally the forgotten reproductive health care clients, and their involvement stops at the clinic door. When accompanying his partner to a health care facility, a man might find no programs encouraging or allowing him to participate in reproductive health decision making or to address his own reproductive and sexual health care needs.

Recently, often at the behest of female clients, health institutions have realized that the constructive involvement of men in reproductive health is essential in order to significantly reduce negative outcomes. However, facilities face several challenges as they try to reach more men: men have only brief contact with reproductive health care systems; providers might not know how to interact and work with male clients; and services for men need to be provided without compromising women's autonomy or their independent access to similar services.

Providers can adapt ANC and FP counseling services to be more couples friendly in order to encourage meaningful male involvement in fistula prevention. Engaging men in interactive, community mobilizing activities that confront harmful traditional practices and myths/taboos concerning gender and reproductive health are

useful strategies to foster effective partnerships between women and men along the fistula care continuum.

Adapted from: Mehta, M., Peacock, D., and Bernal, L. Men As Partners: Lessons learned from engaging men in clinics and communities. Retrieved from www.engenderhealth.org/ia/wwm/pdf/map_genderequal.pdf

For more information on Men As Partners and male involvement in reproductive health, see:

EngenderHealth, 2001. *Men As Partners: A Program for Supplementing the Training of Life Skills Educators, 2nd Edition.* Available at: http://www.engenderhealth.org/pubs/indpubs/ppasamanual.html

EngenderHealth, 2003. Men's Reproductive Health Curriculum. Available at: http://www.engenderhealth.org/res/offc/map/mrhc/index.html#mrhc

Stigma and Discrimination Related to HIV and AIDS

Stigma and discrimination related to HIV and AIDS are a persistent problem in many health care facilities around the world, particularly in those countries hardest hit by the epidemic. Stigma and discrimination result in poor quality of care for those who are infected and ill (or suspected of being infected), frighten away potential clients who need HIV-related and other services, and undermine prevention efforts by limiting access and service utilization. There is a growing body of evidence that suggests that stigma and discrimination in health care settings have contributed to the limited uptake of HIV services such as voluntary counseling and testing and programs for the prevention of mother-to-child transmission of HIV.

Stigma and discrimination in health care facilities have numerous causes, including lack of knowledge among staff about the modes and risk of HIV transmission, and judgmental attitudes and assumptions about the sexual lives of people with HIV. Another significant cause of stigma and discrimination is health workers' fears of becoming infected during the course of their work. In the absence of assurance that they will be protected from the virus, and without access to drugs for postexposure prophylaxis, health workers might engage in behavior that would prevent HIV-positive and other vulnerable individuals from receiving lifesaving care and support.

Some examples of stigmatizing attitudes, behaviors, and actions that have been documented among staff in health care settings include the following:

- Blaming those who are infected with HIV
- Poor treatment of patients who belong to stigmatized populations or clients they believe to be infected
- Breaching client confidentiality by sharing test results with relatives and other staff, publicly marking a client's status
- Discriminating against or not cooperating with colleagues known to be infected with HIV
- Demanding routine, mandatory HIV testing, or insisting on testing as a condition for providing services
- Segregating or isolating HIV and AIDS clients in special beds or wards when there is no clinical need to do so
- Discharging HIV-positive clients, regardless of overall health status, immediately or soon after test results become available

- Withholding treatment from HIV and AIDS clients by treating them less aggressively than other seriously ill clients who are not HIV-positive, or by providing substandard care

Health workers' fears are not unfounded; they are based on real risks resulting from their lack of access to supplies and training in infection prevention and standard precautions. There is mounting evidence that medical transmission is an important and largely neglected route of HIV transmission in resource-poor settings. The number of cases of HIV infection through medical transmission is certainly not trivial; transmission of hepatitis B and C is also a serious risk.

To reduce stigma and discrimination in health care settings, we need to address health care workers' fears about getting infected on the job and their need to protect themselves through standard precautions.

Adapted from: EngenderHealth, 2004. *Reducing stigma and discrimination related to HIV and AIDS: Training for health care workers*. Retrieved from www.engenderhealth.org/res/offc/hiv/stigma/index.html/.

Appendix J

Workshop Evaluation Form

Instructions: For each item, check the box that best reflects your opinion. Your honest responses will help us improve future trainings. Your comments are also welcome.

Name (optional): _____

1. The objectives of the training were:
   - ☐ Very clear
   - ☐ Clear
   - ☐ Not clear

Comments _____

_____

_____

2. The objectives of the training were:
   - ☐ Completely met
   - ☐ Mostly me
   - ☐ Insufficiently met

Comments _____

_____

_____

3. The length of the training was:
   - ☐ Too long
   - ☐ Adequate
   - ☐ Too short

Comments _____

_____

_____

4. The workshop content maintained my interest:
   - ☐ All of the time
   - ☐ Most of the time
   - ☐ Some of the time

Comments _____

_____

_____

5. The material presented in the course was:
   - ☐ Almost all new to me
   - ☐ Mostly new to me
   - ☐ Mostly known to me

Comments _____

_____

_____

6. The skills I acquired are:
   - ☐ Directly applicable to my everyday work
   - ☐ Somewhat applicable to my everyday work
   - ☐ Not very applicable to my everyday work

Comments _____

_____

_____

7. The training facilities were:
   - ☐ Very satisfactory
   - ☐ Somewhat satisfactory
   - ☐ Unsatisfactory

Comments _____

_____

_____

8. What was the best feature of the training?

Comments _____

_____

_____

9. What was the worst feature of the training?

Comments _____

_____

_____

10. What can be improved, and how?

Comments _____

_____

_____

11. Any last words of advice/suggestions?

Comments _____

_____

_____

Appendix K

Sample Client Records and Consent Form

(**Adapted from** Kitovu Hospital Complex, St. Ann's V.V. Fistula Unit, and EngenderHealth client record form for permanent contraception)

REGISTRATION CARD No:_____

Name: _____ Age: _____

Address: _____

Next of kin: _____

Mode of contact of kin: _____

What is your district: _____

Parish/Division: _____

What is the name of your nearest town or village? _____

Have you got a letter from Doctor/Clinic? _____

How many days were you in labor? _____

When was your baby born? _____

Type of delivery: _____

Did you lose control of your urine? _____ and feces? _____

Was that your first labor? _____

Was the baby stillborn? _____

How many babies have you had? _____

How many are alive? _____

Did your husband leave you? _____

How did you hear about this health facility for fistula repair? Unit? _____

Who told you to come to this health facility? _____

Did a "Cured fistula client" tell you to come to this health facility? _____

How did you travel? _____

How far away is home? _____

Who gave you or how did you raise the money for your journey? _____

How many hours in a taxi or bus did it take you to reach here? _____

How much did it cost you? _____

How many days have you been in this health facility? _____

Height:_____ Weight: _____

O/E (Diagram etc.)

Present management _____

Operation Date: _____

Blood group: _____ Transfusion? _____

Results _____

Stress incontinence? _____

Was she given clothes? _____

Transport money? _____

Inpatient number _____

Signed: _____ Date: _____

ADMISSION

Name: _____ Inpatient Number: _____

Address: _____ Age: _____

Referred By: _____ Admission: _____

Surgeon: _____ Discharged: _____

DATE	

INPATIENT NOTES

CONSENT:

FISTULA REPAIR INFORMED CONSENT FORM

I, the undersigned, wish to have leaking of urine/feces or both, which I developed after childbirth, repaired by the following procedure:

_____

(Specify the procedure to be performed to repair leakage of urine/feces or both)

I understand the following:

1. The leakage of urine/feces or both was caused by_____
   _____
   _____
   (Insert the appropriate cause, whether in words, whether obstetric, traumatic or iatrogenic), which has been explained to me.
2. There are no other methods of permanently stopping the leakage of urine/feces or both that I can use except for this surgical procedure.
3. The procedure is a surgical one. Like all surgical procedures, there are some risks and side effects, the details of which have been explained to me.
4. The procedure is not guaranteed to work 100% on all people. There is a failure rate of one out of four people (25%) that undergo the surgical procedure. If the operation is successful, I will manage to control urine/feces or both like I used to before that fateful delivery.
5. I have applied for this surgical procedure of my own free will without coercion or inducement. I can change my mind and refuse the procedure and no medical, health or other services or benefits will be withheld from me as a result.

_____ _____

PRINT THE CLIENT'S NAME SIGNATURE OR THUMB PRINT OF CLIENT

_____

DATE

_____ _____

NAME OF PERSON ATTESTING TO CLIENT'S SIGNATURE NAME OF PHYSICIAN ATTESTING TO CLIENT'S SIGNATURE

_____

DATE

LAB RESULTS

				DATE	SIGNATURE
BLOOD	**Hb=**	**FILM=**	**GRP=**		
URINE					
OTHERS:					

OPERATION NOTES

					DATE	SIGNATURE
LAB RESULTS	BLOOD	Hb=	FILM=	GRP=		
	URINE					
	OTHERS:					

OPERATION NOTES *(continued)*

	POSTOPERATIVE CARE OF FISTULA CLIENTS (Instructions) 1. Vaginal packs removed on 2nd or 3rd postoperative day (as per doctor's instructions). 2. Catheter is removed only on doctor's instructions (usually between 8th and 14th postoperative day). 3. Daily perineal and vulval washing is very important. 4. Care for pressure areas twice daily 5. Client is to be encouraged to move position in bed (catheter secured to pubis thigh) leg exercises to prevent deep-vein thrombosis. 6. May start light diet (low residue) on 1st postoperative day. Must drink plenty of fluid at all times, starting immediately postoperation. 7. Usually client is mobile after 3rd day (as per doctor's instructions) with open drainage.
	ESSENTIALS OF POSTOPERATIVE CARE FOR FISTULA **CATHETER CARE** 1. The urinary catheter must drain freely at all time. If it becomes blocked, the operation fails. 2. Catheter must be strapped to the thigh. 3. Client must not lie on catheter. 4. Catheter or tubing must not be twisted. 5. Drainage tubing must go into a basin or bucket at the side of the bed. The urine should be dripping at all times (open drainage). 6. Client must drink all kinds of fluid freely as soon as she has recovered from anesthesia (at least 500 ml every hour). 7. Urine should be very pale almost like water. If not, patent should drink more. 8. If catheter stops draining or client complains of full bladder, catheter must be irrigated to unblock it immediately and doctor notified. 9. If that fails, doctor has to change catheter (preferably under direct supervision in Lithotomy in Theater) especially following difficult repair.
	DISCHARGE DATE:
	CONDITON:
	REVIEW DATE:

Appendix L

Sample Fistula Counseling Checklist

Preoperative and Immediate Postoperative Periods
Information to Be Provided/Discussed

Client's Name: _____ **Health Facility:** _____

Client's Age: _____ **Client's Parity:** _____ **Planned Date of Surgery:** _____

Name of Counselor: _____ **Date of Counseling:** _____

Instructions: Use this checklist to help guide the counseling session with a fistula client or a fistula client's attendant. After the counseling session, tick the relevant box ☑ to indicate that you have addressed the issue mentioned.
PREPARATION
☐ Assured necessary privacy.
☐ Offered the client a seat.
☐ Greeted client respectfully and with warmth and introduced yourself.
☐ Assessed the client's ability or capacity to give or receive information and whether counseling is appropriate at this time. (If the person does not have the capacity to have a meaningful conversation, thank the person for his/her time and arrange for counseling at another time.)
☐ Assure the person of confidentiality when providing or asking for information.
PREOPERATIVE COUNSELING
Information on fistula
☐ Explored the client's experiences at the facility so far.
☐ Explored attitudes, myths, misconceptions, or religious beliefs related to the fistula.
☐ Provided accurate information on the formation of a fistula.
☐ Provided accurate information on how fistula can be prevented.
Surgical procedure
☐ Explored the client's feelings/concerns and issues about the surgical procedure.
☐ Provided information on surgical procedure: intake, client assessment, surgery, healing process, discharge, etc.
Information on hospital routines and services
☐ Explored any attitudes, myths, misconceptions, or religious beliefs related to the fistula.
☐ Provided the client with information on hospital routines and services: Hospital services food, accommodation, toilets, attendants, hygiene, etc.
☐ Provided the client with information on other available services: counseling, transport refund, HIV counseling and testing, family planning, etc.

Sample Fistula Counseling Checklist
Preoperative and Immediate Postoperative Periods

Support in the facility

- ☐ Explored the social/emotional support needs for the client (partner, family member, other attendant).
- ☐ Informed the client of the availability of counseling and social support groups within the facility.

Closing the counseling session

- ☐ Asked if the client had any additional needs or feelings s/he would like to discuss.
- ☐ Asked if the client had any fears or concerns s/he would like addressed.
- ☐ Asked if the client had any additional questions, and answered these appropriately or referred the client to other staff.
- ☐ Shared success stories, as appropriate.

Briefly describe the counseling session and any important issues that came up:

POSTOPERATIVE COUNSELING

Immediate postoperative period

- ☐ Discussed with client how she felt after surgery.
- ☐ Explored the client's feelings/concerns and issues following surgery.
- ☐ Identified any side effects, risks, or complication and developed a plan of action in case of risk or complication.

Support in facility

- ☐ Explored the social/emotional support needs for the client (partner, family member, other attendant).
- ☐ Informed the client about the availability of counseling and social support groups within the facility.

Closing the counseling session

- ☐ Asked if the client had any additional needs or feelings s/he would like to discuss.
- ☐ Asked if the client had any fears or concerns she would like addressed.
- ☐ Asked if the client had any additional questions, and answered these appropriately or referred the client to other staff.
- ☐ Shared success stories, as appropriate.

Briefly describe the counseling session and any important issues that came up:

Sample Fistula Counseling Checklist

Discharge/Follow-Up Periods
Information to Be Provided/Discussed

Client's Name: _____ **Date of Surgery:** _____

Name of Counselor: _____ **Date of Counseling:** _____

Instructions: Use this checklist to help guide the counseling session with a fistula client or a fistula client's attendant. After the counseling session, tick the relevant box ☑ to indicate that you have addressed the issue mentioned. **Make sure to review the notes from the previous counseling session before beginning the session. Review any important issues that arose in the previous session with this client.**
PREPARATION
☐ Assured necessary privacy.
☐ Offered the client a seat.
☐ Greeted the client respectfully and with warmth and introduced yourself.
☐ Assessed the client's ability or capacity to give or receive information and whether counseling was appropriate at this time. (If the person does not have the capacity to have a meaningful conversation, thank the person for his/her time and arrange for counseling at another time.)
☐ Assure the person of confidentiality when providing or asking for information.
COUNSELING
☐ Explored the client's needs/concerns at discharge.
☐ Discussed the possible complications and risks related to surgery after discharge.
☐ Discussed with the client an action plan in case of complications after discharge.
☐ Discussed with the client the importance of follow-up after discharge.
☐ Discussed with the client/attendant how she/the client needs to take care of herself at home, including:
◦ Hygiene
◦ The importance of abstinence from sexual activity and its benefits (6 months)
◦ Development (with the client) of an action plan for abstinence
◦ The risk of sexually transmitted infection, including HIV (if client has been abstaining)
◦ The importance of delaying pregnancy for one year and the available contraceptive methods and family planning services in the community
◦ Development (with the client) of an action plan on how she will not get pregnant/or will obtain a method of family planning
◦ The importance of attending antenatal care, having a birth plan, and delivering at a health care facility/having a cesarean delivery if the client becomes pregnant

Sample Fistula Counseling Checklist
Discharge/Follow-Up Periods

RECAP OF INFORMATION ON FISTULA (important to ensure that the client can prevent fistula in future)

- ☐ Explored attitudes, myths, misconceptions, or religious beliefs related to the fistula.
  - ☐ Provided accurate information on the formation of a fistula.
  - ☐ Provided accurate information on how fistula can be prevented.

SUPPORT IN THE COMMUNITY

- ☐ Explored the social/emotional support needs for the client at home (partner, family member).
- ☐ Informed the client of the availability of counseling at the facility.
- ☐ Explored the economic and other support needs of the client in the community.
- ☐ Discussed what income-generating activities or educational opportunities the client has, or what might be possible/available.
- ☐ Explored opportunities in the client's community (such as community organizations or economic or social support organizations/religious groups) that may be of assistance.
  - ☐ Provided links to community organizations or other forms of support, where available.
- ☐ Asked the client if s/he had any concerns related to family members that s/he wanted to discuss.

CLOSING THE SESSION

- ☐ Asked if the client has any additional fears or concerns that you can address.
- ☐ Asked if the client had any additional questions, and answered these appropriately or referred the client to other staff.
- ☐ Discuss the importance of follow-up and make a plan for a follow-up visit.
- ☐ Share success stories as appropriate.

Briefly describe the counseling session and any important issues that came up:

Sample Fistula Counseling Register

Instructions: For every client who receives any counseling, enter the client's name and age and the date of each counseling session. For each type of counseling, put a tick (✓) in the appropriate box to indicate whether the counseling was done in a group or an individual session. Enter the name of the counselor who conducted the counseling session and any major issues that came up in the counseling session that may require follow-up counseling.

Client Name	Age	Date of Counseling	Type of Counseling	Group	Individual	Counselor	Comments on Counseling Session Describe any major issues that came up in counseling
			Preoperative				
			Postoperative				
			Discharge/follow-up				
			Reintegration				
			Preoperative				
			Postoperative				
			Discharge/follow-up				
			Reintegration				
			Preoperative				
			Postoperative				
			Discharge/follow-up				
			Reintegration				
			Preoperative				
			Postoperative				
			Discharge/follow-up				
			Reintegration				

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