

A SUPPLEMENT TO THE OBSTETRIC  
FISTULA COUNSELING CURRICULUM

# Counseling

the Traumatic Fistula Client



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*A Supplement to the Obstetric Fistula Counseling Curriculum*



**USAID**  
FROM THE AMERICAN PEOPLE



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EngenderHealth acknowledges with gratitude the input and efforts of those who tirelessly work to improve the lives of women and girls affected by traumatic fistula. While recognizing that traumatic fistula can occur in any conflict or postconflict setting where rape is used as a weapon of war, and even in otherwise peaceful areas that experience occasional or localized instability, this document has benefited greatly from the experience of service providers in the Democratic Republic of Congo, where the problem was especially severe at the time this supplement was developed. EngenderHealth wishes to thank the staff and management of both Heal Africa Hospital (Goma, North Kivu) and Panzi Hospital (Bukavu, South Kivu), who hosted a site visit in September 2008, generously shared their experiences in the provision of services for traumatic fistula, and provided guidance on key themes to be included in traumatic fistula counseling training. Dr. Ahuka Longombe, Professor of Surgery, University of Kisangani School of Medicine, and Dr. Pascal Manga, Obstetrician-Gynecologist, Universities of Kindu, Kisangani, and Lubumbashi, and Maternité Sans Risque Program, Kindu, have provided invaluable input on the training content. They openly shared their wealth of experience in traumatic fistula repair and counseling, which greatly enhanced the applicability of this document.

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Although traumatic fistula presents unique medical and counseling challenges, some aspects of treatment and care are similar to what is offered to obstetric fistula clients. EngenderHealth's publication *Counseling the Obstetric Fistula Client: A Training Curriculum* guided the format and informed some aspects of the content of this document. This volume is a supplement to that publication, and the two are designed to be used jointly.

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# Background

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Traumatic fistula has been defined as “an abnormal opening between the reproductive tract of a woman or girl and one or more body cavities or surfaces, caused by sexual violence, usually but not always in conflict and postconflict settings (Addis Ababa Fistula Hospital et al., 2006).” It is a devastating medical condition that is usually accompanied by equally serious psychological impact. It is most often observed during periods of conflict in countries where warring parties use violent and systematic rape to destroy communities through attacks on women and girls.

Rape as a weapon of war is not new, and it is likely that some number of women and girls have silently suffered with traumatic fistula as a result of conflict-related sexual attacks in a variety of current and historical conflicts. Today, sexual violence is a tragic hallmark of conflicts in the Democratic Republic of Congo (DRC), especially in the eastern and central provinces, and the Darfur region of Sudan. However, in recent times, it has also been documented in many other countries in Africa, including Liberia, Rwanda, Sierra Leone, and conflict-affected areas of Uganda, as well as in other places around the world, such as East Timor and Kosovo. Conflict-related sexual violence can erupt at certain periods of time, or in specific locations, in otherwise peaceful countries. In Kenya, for example, an increase in sexual violence reporting was noted during election-related insecurity in late 2007 and early 2008, and rape is frequently used during cattle raids in certain parts of the country. Although sexual violence under such circumstances is perhaps less widespread, women and girls remain at risk for rape-related injuries, including traumatic fistula. Even in locations where conflict has disrupted societies for years, such as in the DRC, there have been documented peaks in cases of sexual violence and traumatic fistula, reflecting periods of heightened insecurity.<sup>1</sup>

The global burden of traumatic fistula is unknown, and even country-level statistics are difficult to estimate. Traumatic fistula is in many ways a hidden problem. The severe stigma associated with rape in many societies, in addition to the isolating effect of fistula symptoms, can hinder women from coming forward to seek treatment, especially if they are unaware that treatment exists. Women needing medical care may live too far from services to easily access them, even if these are available. Hospital or fistula clinic counts, which are typically used to measure magnitude, are only able to capture the data on those women whom they are able to help; clinics cannot measure the cases of women who never come for treatment. Women and girls who do reach help do not always feel comfortable sharing information about sexual violence with providers, and the underlying cause of the fistula may become clear only as a result of active questioning

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1 Information provided by Manga Okenga, Maternité Sans Risque Hospital, Kindu, DRC, in in-person informational interview, June 21, 2008. Kampala, Uganda. Traumatic fistula treatment and counseling at the Maternité Sans Risque Hospital.

by the medical staff. In addition, cases classified as obstetric fistula may in fact be due to complications at delivery of an infant conceived from sexual violence. This may further confuse any available statistics (EngenderHealth, 2009).

Across locations, there is considerable variation in estimates of traumatic fistula magnitude. However, the following observations highlight the extent of damage caused by traumatic fistula in various settings:

- Referencing a report of 4,715 sexual violence survivors who were received at the Heal Africa Hospital (previously Doctors on Call for Service/Heal Africa Hospital) in Goma, DRC, between April 2003 and June 2006, Longombe, Kasereka, and Ruminjo (2008) note that 702 patients (17.5%) suffered from genital fistula. Of all the fistula patients, 63.4% had experienced traumatic fistula.
- Panzi General Referral Hospital (in Bukavu, DRC) offers fistula repair services to women and girls, who include a number of survivors of conflict-related sexual violence. According to a review of hospital records covering the period November 2005 to November 2007 (Onsrud et al., 2008), 4% were caused by sexual violence.<sup>2</sup>
- During the period March 2002 through December 2007, medical staff at the Maternité Sans Risque Hospital in Kindu, DRC, treated 341 traumatic fistula cases due to sexual violence. As mentioned earlier, the proportion of fistula cases due to sexual violence, compared with obstetric and other causes, fluctuates according to the level of insecurity. In this location, 2003 is noted as having been the worst year, when it is estimated that 70–80% of all fistula cases could be classified as due to sexual violence.
- In 2006, the United Nations Population Fund (UNFPA) and partners in Liberia conducted a study of 48 medical centers throughout four counties there (Lofa, Bong, Nimba, and Montserrado), in which they found that of 351 fistula repair surgeries between January 2004 and December 2005, 13% were traumatic fistula cases (though this was defined to include both rape-related fistula and fistula due to iatrogenic causes) (Mulbah, 2006; Mulbah, 2008).
- UNFPA estimates that there are 5,000 new fistula cases per year in Sudan, though it is unclear how many women may suffer from traumatic fistula. That more than 60% of fistula cases are believed to occur in conflict-affected Western Darfur is, however, a likely indication of a significant traumatic fistula burden (UNFPA, 2007).
- In 2005, it was reported that two-thirds of Sudanese refugee women and girls who had had fistula repair surgery at the Abéché Regional Hospital in Eastern Chad had been raped by Janjaweed militia in Darfur (UNHCR, 2005).

The women and girls who live through the attacks that lead to traumatic fistula are survivors. Their resilience is a source of strength upon which to build the services that can best support their recovery. They need protection, legal support, social services, and high-quality medical care and counseling. In many cases, the hospital and clinic staff who provide medical care are not trained counselors, and sexual violence survivors often are referred to other organizations for psychosocial care. For traumatic fistula clients, however, counseling within the clinical setting is a critical component of care and recovery at all phases. Without adequate and appropriate counseling, women and girls may lack a full understanding of their physical condition and physical remedies. They may become retraumatized by the medical examination, and they may experience strong emotional reactions before and after surgery. If family members are not

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2 Information provided by Manga Okenga, Maternité Sans Risque Hospital, Kindu, DRC, in in-person informational interview, June 21, 2008. Kampala, Uganda. Traumatic fistula treatment and counseling at the Maternité Sans Risque Hospital.

counseled properly, patients' postoperative care may be inadequate and may lead to further complications. Traumatic fistula clients often require follow-up counseling and support to be successfully reintegrated into their communities.

In September 2005, in Addis Ababa, Ethiopia, EngenderHealth hosted an experts' meeting on traumatic fistula. Among the key challenges in providing traumatic fistula care, participants identified the 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 the difficulty in maintaining continuity of care in providing long-term psychological and emotional counseling after fistula repair. They also indicated that developing standards and guidelines for counseling traumatic fistula clients is a key strategy for addressing clients' counseling needs.

The rationale for this curriculum supplement is to support the training of counselors and health care providers who work with traumatic fistula clients. Excellent examples of counseling and medical care for women and girls with traumatic fistula have emerged from the DRC, where the problem is particularly pronounced at this time. Physicians, other medical staff, and counselors at Heal Africa Hospital (Goma), Panzi Hospital (Bukavu), and the Maternité Sans Risque Clinic (Maniema) have created comprehensive fistula and sexual violence response programs under some of the most extreme circumstances, including insecurity, limited resources, logistical challenges, and political instability. Additionally, counseling on conflict-related sexual violence and on both the medical and social concerns of women with obstetric fistula is conducted in a number of conflict-affected countries, including Chad, Ethiopia, Liberia, Rwanda, Sierra Leone, Somalia, Sudan, and Uganda, as well as in other countries that at the time this document was developed were not experiencing widespread insecurity, such as Bangladesh, Benin, Guinea, Niger, Nigeria, and others.

There are several areas of overlap in service delivery for traumatic and obstetric fistula clients. The physical consequences of fistula and many of the psychosocial consequences of living with the condition are the same. In both cases, the medical information that clients need to receive throughout the treatment process is very similar, regardless of the cause of the fistula. Clients suffering from traumatic fistula, like those who have endured obstetric fistula, need counselors who have strong communication skills, who can explain what fistula is and discuss related medical issues, who are knowledgeable about their clients' emotional concerns, who can facilitate the provision of information to family members during care and recovery, who understand the challenges of community reintegration, and who can at all times provide services with privacy and confidentiality. Because of these similarities, this supplement is designed to be used in conjunction with EngenderHealth's obstetric fistula training curriculum, *Counseling the Obstetric Fistula Client*. However, the conditions that lead to traumatic fistula fundamentally impact clients' needs, especially their psychosocial needs.

Another significant difference in counseling traumatic and obstetric fistula clients lies in their age range. Obstetric fistula clients are by definition women of childbearing age. Often they are young women, at the beginning of their childbearing years. However, traumatic fistula clients can also be young girls. The types of physical damage they may sustain from sexual violence and the medical repair process can differ from those of more fully developed clients. In addition, girl clients' understanding of what has happened to them, their emotional reactions, and their counseling needs may differ from those of adult clients. Although young girls represent a minority of all traumatic fistula clients, they are seen in every clinic that addresses

traumatic fistula, and the burden of their physical and psychological wounds is great. This curriculum supplement offers training participants the opportunity to explore counseling issues for girl clients. However, many other resources, professional networks, and programmatic efforts address the needs of children who have experienced sexual violence in general, and this supplement is not designed to address this aspect completely.

This curriculum supplement builds on important work that has already been done in this area and has incorporated the ideas and feedback of experts in the field. As a preliminary step, EngenderHealth contacted several participants in the 2005 experts' meeting described above to gather more information about current counseling approaches and to identify training needs in a more detailed way. In September 2008, a consultant for EngenderHealth traveled to Heal Africa Hospital and Panzi Hospital to talk with a variety of staff, including the hospital directors, fistula repair surgeons, nurses, counselors, social workers, and gender-based violence program managers, as well as other referral service providers, to learn about current counseling practices and challenges in the field, as well as to more specifically detail those areas that practitioners identify as key training concepts.

In March 2009, after an initial draft of this document had been completed, EngenderHealth and the Regional Centre for Quality of Health Care (RCQHC) hosted a technical workshop in Kampala, Uganda, at which experts from DRC and Uganda provided feedback on materials and additional input on key training concepts. As noted by colleagues at the RCQHC, although there are currently no internationally recognized standards of care for traumatic fistula, the hospitals and clinics that work with traumatic fistula clients every day have accumulated a wealth of experience (Mugerwa, 2009). Through the site visits, informational interviews, and feedback from experts in DRC and Uganda, this curriculum supplement draws directly on those experiences.

This supplement, the final product of the process, is intended to help providers offer traumatic fistula clients the most comprehensive counseling possible. While drawing on the expertise and input of those working where traumatic fistula occurs most notably today, the sessions included here have been drafted for relevance in any country where traumatic fistula may pose a service delivery challenge, either currently or in the future. Ideally, training on traumatic fistula counseling will become less relevant overall when conflict can be resolved and prevented and when women and girls are no longer targeted for violence.

# Introduction for the Trainers

## NOTE TO TRAINERS

*Counseling the Traumatic Fistula Client* is a supplement to EngenderHealth's *Counseling the Obstetric Fistula Client: A Training Curriculum*. Much of the content in that curriculum is also applicable to counseling the traumatic fistula client. However, because traumatic fistula is the result of sexual and gender-based violence, additional or different issues also need to be addressed in the training. That is the purpose of this supplement.

Throughout the obstetric fistula training curriculum, you will find pink boxes like the one shown below:

*Refer to pages 19 and 20 of the traumatic fistula supplement for alternative Handout 1-B, which may replace the supplement provided 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 this supplement. It will provide you with important factual material and training exercises specific to traumatic fistula, including alternative or supplemental participant handouts.

Following each item in this supplement, boxes like the one shown below direct you back to the appropriate page and topic in the obstetric fistula training curriculum.

*Go to page 27 in the obstetric fistula training curriculum—Training Methods.*

Note that this kind of indicator always follows the description of a training activity, and that subsequent pages of the supplement may contain participant handouts that are to be used in the activity. However, the box is not provided at the end of the handout, as this information is not necessary or useful for the training participant. Trainers need to keep the handouts in mind when incorporating an activity from this supplement into the fistula counseling training.



# Session 1

## Opening Session

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The primary goal of the opening session is to orient the training participants to the goals and objectives of the workshop, establish workshop norms and logistics, and identify the elements that form the core of a comprehensive approach to addressing fistula.

To integrate a discussion of traumatic fistula into this session, refer to the following elements in this supplement (as directed in the blue box instructions in the obstetric fistula training curriculum):

- Supplemental Resource: Alternative list of Points to Remember (page 8)
- Alternative Appendix B—Pretest/Posttest on Fistula Counseling (pages 9–11)
- Alternative Handout 1-B (pages 12 and 13)
- Supplemental Resource: Alternative flipcharts on “Three Elements of Comprehensive Fistula Management” (page 14)
- Alternative Appendix C—Pretest/Posttest on Fistula Counseling Answer Key (pages 15–18)
- Supplemental Resource: Additional Activity 3 Training Steps (page 19)



## Supplemental Resource

### POINTS TO REMEMBER

- ✓ Counseling is an integral part of the comprehensive approach to traumatic fistula care services.
- ✓ The three elements that make up the core approach to addressing traumatic fistula are:

#### Prevention

- Support to community efforts to enhance the protection of women and girls against sexual violence, and national and international advocacy efforts to stop gender-based violence
- 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 care facilities (within the community and to/from other health care 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
- ✓ Prevention of traumatic fistula is directly linked to sexual violence prevention efforts.

*Go to page 18 in the obstetric fistula training curriculum—Training Methods.*

## Alternative Appendix B

# Appendix B

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## Pretest/Posttest on Traumatic Fistula Counseling

1. State the three elements that form the core of a comprehensive approach to helping women with traumatic fistula and their families.
  1. \_\_\_\_\_
  2. \_\_\_\_\_
  3. \_\_\_\_\_
  
2. When could counseling of the traumatic 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 and b
  
3. Where does counseling for the traumatic fistula client happen?
  - a. In a private room with a door
  - b. Anywhere at the service site where confidentiality and privacy can be ensured
  - c. At a community meeting place
  - d. None of the above
  - e. Both a and b
  
4. Give one example of how you can respect a traumatic 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 and 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 traumatic fistula client before she is discharged?
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
9. List three emotional reactions that traumatic fistula clients may experience before, during, or after traumatic fistula care.
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 a traumatic fistula that occurred after sexual assault. 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 traumatic fistula and how this could affect care.

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15. List three important issues to address when counseling the traumatic fistula client and her partner together.

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

16. List three issues that might be better explored in a counseling session with the client alone, rather than with her and her partner together.

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

*Return to page 18 in the obstetric fistula training curriculum—Materials.*

## Alternative Handout

# Alternative Handout 1-B

## Workshop Schedule

Session	Participants	Time
<b>Session 1: Opening Session</b>		
Part A: Registration and Pretest	All	Morning, Day 1
Part B: Opening Remarks	All	
Part C: Workshop Introduction	All	
<b>Session 2: Providers' Values and Attitudes</b>		
Part A: The Mental Health–Physical Health Connection and Providers' Role in Psychosocial Care	All	Morning/ Afternoon, Day 1
Part B: Values and Attitudes	All	
Part C: Informed Choice, Informed Consent, and the Rights of the Client	All	
<b>Session 3: Understanding Traumatic Fistula</b>		
Part A: Description of Problem	Nonphysicians	Afternoon, Day 1
Part B: Causes of Fistula	Nonphysicians	
Part C: Health and Social Consequences of Traumatic Fistula	Nonphysicians	
Part D: Reasons Why Women Do Not Seek Care	Nonphysicians	
Part E: Traumatic Fistula and Psychosocial Impact at the Individual, Family, and Community Levels	Nonphysicians	
<b>Session 4: Understanding the Client's Perspective</b>		
Part A: Understanding the Clients' Perspective	Nonphysicians	Morning, Day 2
Part B: The Psychosocial Response to Sexual Violence and Traumatic Fistula	All	
Part C: Developing Case Studies of Traumatic Fistula Patients	All	
Part D: Confidentiality, Privacy, and Dignity	All	
<b>Session 5: Interpersonal Communication</b>		
Part A: Two-Way Communication	All	Afternoon, Day 2
Part B: Verbal and Nonverbal Communication	All	
Part C: Active and Effective Listening	All	
Part D: Asking Open-Ended Questions	All	
Part E: Positive Feedback through Paraphrasing, Praise, Encouragement, and Empathy	All	
Part F: Using Simple Language and Visual Aids	All	
Part G: Counseling Framework: REDI	All	

Session	Participants	Time
<b>Session 6: Counseling for the Traumatic Fistula Client</b>		
Part A: Overview of counseling	All	Morning/ Afternoon, Day 3
Part B: Counseling for Traumatic Fistula Clients (Psychosocial and Physical Health Issues)	All	
Part C: Counseling Women and Children with Special Needs	Nonphysicians	
<b>Session 7: Family Planning and Related Health Concerns</b>		
Part A: Unwanted Pregnancy Counseling and Emergency Contraception	All	Morning, Day 4
Part B: Family Planning	All	
Part C: Sexually Transmitted Infections and HIV Postexposure Prophylaxis	Nonphysicians	
<b>Session 8: Counseling for the Client's Family</b>		
Part A: Impact of Sexual Violence and Traumatic Fistula on Husbands and Families	All	Afternoon Day 4/ Morning Day 5
Part B: Overview of Counseling for the Client's Family	Nonphysicians	
Part C: Counseling during Admission and the Preoperative Period	Nonphysicians	
Part D: Counseling after Surgery	Nonphysicians	
Part E: Counseling at Discharge	Nonphysicians	
<b>Session 9: Supporting the Traumatic Fistula Client</b>		
Part A: Forming Client Support Groups within a Facility	Nonphysicians	Afternoon Day 5
Part B: Using Success Stories	Nonphysicians	
Part C: Linkages with the Community	Nonphysicians	
Part D: Male Involvement at the Community Level	Nonphysicians	
<b>Session 10: Clinical Practicum</b>		
Observation and Counseling of Fistula Clients	All	Day 6/ Morning Day 7
<b>Session 11: Supporting the Provider/Workshop Wrap-Up</b>		
Part A: Overview of Provider/Counselor Challenges and Impact of Working with Traumatic Fistula Clients	All	Afternoon Day 7
Part B: Managing Stress and Preventing Burnout	All	
Part C: Self-Care	All	
Part D: Conclusion	All	

*Return to page 18 in the obstetric fistula training curriculum—Advance Preparation.*

Supplemental Resource

*Three Elements of Comprehensive Fistula Management*

**Prevention**

- Support to community efforts to enhance the protection of women and girls against sexual violence, and national and international advocacy efforts to stop gender-based violence
- Early methods of prevention
  - Nutrition
  - Education for girls
  - Avoidance of early childbearing
  - Family planning

**Prevention (continued)**

- 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 care facilities (within the community and from other facilities)
- Access to surgical treatment, including preoperative 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

*Return to page 19 in the obstetric fistula training curriculum—Step 6 in Advance Preparation.*



## Alternative Appendix C

# Appendix C

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## Pretest/Posttest on Traumatic Fistula Counseling Answer Key

1. State the three elements that form the core of a comprehensive approach to helping women with traumatic fistula and their families. (3 points)
  1. **Support to community efforts to enhance the protection of women and girls against sexual violence**
  2. **Access to surgical treatment, including preoperative and postoperative care**
  3. **Social reintegration, physical rehabilitation, and counseling and emotional support**
2. When could counseling of the traumatic 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 and b
3. Where does counseling for the traumatic fistula client happen? (1 point)
  - a. In a private room with a door
  - b. Anywhere at the service site where confidentiality and privacy can be ensured
  - c. At a community meeting place
  - d. None of the above
  - e. Both a and b
4. Give one example of how you can respect a traumatic 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 and 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 essential information on family planning that you should tell every traumatic 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 traumatic 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 emotional reactions that traumatic fistula clients may experience before, during, or after traumatic fistula care. (3 points)

Possible responses include:

- **Guilt and self-blaming**
- **Shame and feelings of dirtiness**
- **Loss of self-confidence**
- **Mood swings**
- **Loss of self-esteem**
- **Depression**
- **Fear**
- **Anguish/sorrow**
- **Anger**
- **Withdrawal and isolation**
- **Powerlessness**
- **Denial/negation**

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 a traumatic fistula that occurred after sexual assault. Using simple language, explain to the client what is happening in her body. (2 points)
- A traumatic fistula develops as a result of internal injuries during very violent rape, resulting in a hole between the vagina and bladder or between the vagina and rectum or both. Urine and/or feces pass uncontrollably through this hole.**
14. Explain how beliefs can influence the care that providers give. Give one concrete example of a belief, value, or judgment about traumatic 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 women who have been raped need to be strong and face their difficulties quietly so that they can get on with their lives, the provider might have difficulty providing empathetic care.**
  - **If a provider believes that an adolescent with traumatic fistula should not be having regular sexual intercourse until she is older, she might not discuss appropriate family planning options.**
15. List three important issues to address when counseling the traumatic 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.**

16. List three issues that might be better explored in a counseling session with the 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**

*Return to page 21 in the obstetric fistula training curriculum—Part B: Opening Ceremony.*

## Supplemental Resource

### Activity 3: Presentation/Discussion (10 minutes)

1. Ask the participants to take a piece of paper and write down three elements that form the core of a comprehensive approach to helping women with traumatic fistula and their families.
2. Ask for volunteers to offer their ideas, and write down some of the key suggestions on flipchart paper, clustering similar comments together as much as possible.
3. Facilitate a discussion, comparing participants' responses to the prepared flipchart.
4. Outline the ways in which several of the training session topics will address the core elements, primarily in the areas of treatment and reintegration.

*Go to page 31 in the obstetric fistula training curriculum—Session 2: Providers' Values and Attitudes.*



## Session 2

# Providers' Values and Attitudes

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Health care providers working with traumatic fistula clients note that such women's decisions about treatment—and, ultimately, whether they can be healed—often depend on a client's psychosocial state, including her emotional state, how she views her options and constraints, her understanding and cultural beliefs about her own body, and what she expects to happen to her as a result of medical care (i.e., whether she thinks it will help her, if she thinks it is dangerous, etc.). Thus, it is crucial that providers be sensitive to psychosocial issues related to traumatic fistula.

To integrate a discussion of traumatic fistula into this session, refer to the following elements in this supplement (as directed in the blue box instructions in the Obstetric Fistula training curriculum):

- Alternative Session 2 Overview: Session Objectives, Points to Remember, Training Methods, Materials, Advance Preparation, and Training Tip (pages 22–25)
- Supplemental Resource: Supplement 2A—Part A: The Mental Health–Physical Health Connection and Providers' Role in Psychosocial Care (pages 26–28)
- Supplemental Handout 2-a: Case Study—Democratic Republic of Congo (pages 29 and 30)
- Supplemental Handout 2-b: Case Study—Northern Uganda (pages 31 and 32)
- Supplemental Resource: Alternative Trainer's Resource 2-D—Sample Value Statements for Part B, Activity 5 (pages 33 and 34)
- Supplemental Resource: Part B, Activity 6—Additional Examples of How Values and Attitudes Can Influence the Quality of Care (page 35)



## Alternative Session 2 Overview

# Session 2 Overview

## Session Objectives

As a result of this session, the participants will be able to:

- 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
- Identify the range of reasons health care workers may resist talking with clients about the traumatic background to their fistula condition
- Explain why health care workers may have specific security concerns in addressing the needs of sexual violence survivors
- Explore ways to help clients talk about sexual violence
- Explain the importance of being aware of one's own values and attitudes and avoiding 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 and understand 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.
- ✓ 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.

*(continued)*

**POINTS TO REMEMBER (continued)**

- ✓ 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.
- ✓ While the mental and physiological consequences of fistula affect all women with the problem, traumatic fistula clients also must deal with the psychosocial effects of the sexual violence that led to their developing the condition.
- ✓ Addressing the sexual violence experience with traumatic fistula clients is a crucial first step in helping women and girls get the support they need; the client may not have discussed the experience with anyone else, and the act of breaking the silence can offer the client hope (*adapted from: UNFPA, 2001*).
- ✓ Staff can play a key role in helping clients discuss the traumatic nature of their medical condition, but they may be reluctant to do so (e.g., it may be a challenge for staff to screen for/ask clients about sexual violence and psychosocial trauma). Some staff may resist asking about sexual violence for a variety of reasons:
  - They often face significant time constraints.
  - They may not consider sexual violence to be a health issue (i.e., it is not part of their responsibility).
  - They may believe that women will deny it and/or feel ashamed.
  - They may feel overwhelmed by the issue and believe that they cannot do anything to help. (*Adapted from: Bott et al., 2010*)
- ✓ In some settings, health care workers who provide medical and counseling assistance to survivors of conflict-related violence also face personal security threats from armed groups because of their work.
- ✓ Staff throughout the organization can support traumatic fistula clients by providing support, understanding, validation, and information (*adapted from: UNFPA, 2001*).

**Training Methods**

- Warm-up
- Large-group exercise
- Discussion
- Case study
- Role play
- 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
- Supplemental Participant Handout 2-a: Case Study—Democratic Republic of Congo
- Supplemental Participant Handout 2-b: Case Study—Northern Uganda
- 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 the 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 Time (total): 4 hours 15 minutes*

*Go to page 34 in the obstetric fistula training curriculum—Session 2 Training Steps.*

Supplemental Resource

# Supplement 2A

## PART A: The Mental Health–Physical Health Connection and Providers' Role in Psychosocial Care

### NOTE TO TRAINERS

This supplement uses a case study to help the training participants explore the range of clients' beliefs, emotions, and understanding, all of which can lead women who face the same medical problem to make different decisions. The exercise is based on a case study focused on sexual violence and traumatic fistula. Supplemental Handout 2-a and the discussion questions found at the end of the handout are crucial to the success of this activity.

*Time: 1 hour, 15 minutes*

### Activity 1: Warm-Up (15 minutes)

1. Provide a sheet of writing paper to each participant.
2. Ask the participants to individually write about an experience they have had in providing care to a sexual violence survivor that was especially challenging. This may have been because of the emotional state of the client, because the case took longer than anticipated and created a backlog, because of personal security concerns in getting involved in the case, or for some other reason.
3. In addition to describing the case, ask the participants to write about how it made them (the providers) feel and how they handled the situation.
4. Explain that you would like to use some of these descriptions to start a discussion about the challenges that health providers face when helping sexual violence survivors and the impact it can have on them as individuals. Participants should feel free to write about their situation anonymously.
5. Allocate 10 minutes for the writing part of this activity. When the participants have finished writing, collect the stories and select a few at random to read aloud.
6. Guide a five-minute open discussion about some of the reasons why health care providers may be reluctant to address sexual violence in their work, noting that even those with years of experience in this work may encounter situations that make them feel uncomfortable. Guide the discussion to focus also on solutions that the participants may have developed to help them address difficult issues.

**TRAINING TIP**

Health care providers and counselors face many constraints in their day-to-day work that can hinder effective discussions about sexual violence. Even staff at specialized health care centers for sexual violence may encounter especially challenging cases and even face personal security threats because of their work. The warm-up activity above is designed to help the participants articulate reasons why it can be a challenge for providers to talk with clients about sexual violence. It is also designed to encourage the participants to share their solutions with each other. For some participants, discussion of difficult past cases may be distressing. Remember that the participants should not feel pressured to discuss their experiences if they are uncomfortable doing so. However, they may benefit from hearing about similar challenges faced by other participants and from talking about solutions.

A key point to raise in this activity is that providers working with traumatic fistula clients can face constraints in addressing the sexual violence experiences that have brought women and girls to the health facility (see Key Points). Yet clients will have a difficult time healing physically without addressing psychosocial aspects, and providers can also find solutions to even the most challenging situations.

**Activity 2: Case Study (15 minutes)**

1. Ask the participants to form groups of 5–6 persons. Each group will use one of two case studies (either Supplemental Handout 2-a or Supplemental Handout 2-b) for this activity.
2. Distribute one copy of Supplemental Handout 2-a or Supplemental Handout 2-b to each participant. All of the participants within each group should be using the same case study.
3. Participants should read the case study and talk about it, using the questions.
4. One participant from each group should briefly summarize the key points from their group's discussion.
5. As a group, identify all of the possible scenarios that could form the ending of this case study.
  - For the case study in Supplemental Handout 2-a, the client might want to get the operation but is concerned that her husband will reject her anyway; the client might decide not to get the operation and might go back to her community to face the possibility of isolation and rejection; or she might decide not to get the operation but does not want to go back to her community.
  - For the case study in Supplemental Handout 2-b, the young woman might start to develop trust in the health care workers, depending on counseling techniques; or the health clinic staff might seek the help of religious leaders.

## TRAINING TIP

Health care providers working with traumatic fistula clients note that the psychosocial status of the client, including her emotional state, how she views her options and constraints, her understanding and cultural beliefs about her own body, what she expects to happen to her as a result of medical care (i.e. whether she thinks it will help her, if she thinks it is dangerous, etc.) can all affect her decisions about treatment and ultimately whether she can be healed. This case study should help the participants explore the many different possibilities that can arise from one scenario, as different clients will have different beliefs, emotions, and understanding, all of which can lead women who face the same medical problem to make different decisions.

### Activity 3: Role Play (45 minutes)

1. Ask the participants to divide into groups of 5–6 persons each.
2. Assign a role to every member in each of the groups, including client, family member, nurse, surgeon, psychologist/counselor, and any other character that the groups might think of (e.g., other patients, other hospital staff, community members).
3. Ask the groups to design and perform a brief skit to describe one of the outcomes identified in Step 5 of Activity 1 above.
4. After the skits have all been performed, facilitate a brief discussion about the outcomes presented, focusing especially on any values and attitudes that the providers (surgeon, nurses, counselors) may have shown in their roles.

*Return to page 34 in the obstetric fistula training curriculum—Step 3 in Part A, Activity 1.*



## Supplemental Handout

## Supplemental Handout 2-a

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### Case Study—Democratic Republic of Congo

*This case study was presented in the article “Fistula and traumatic genital injury from sexual violence in a conflict setting in eastern Democratic Republic of Congo” (Longombe, Kaserka, & Ruminjo, 2008). It is presented below verbatim, with the omission of the last two sentences, to allow for discussion of possible outcomes. It is the story of a woman named Rehema, who was 34 years old when she was brutally raped by five armed men.*

Because I could not conceive, my husband decided to take a second wife, and they eventually had four children. My co-wife could not stand to see me touch her children; she called me a witch, a sterile witch. My life with them became miserable and unhappy. So, I dedicated myself to prayer and hoping that I would one day conceive.

Years later, when I was over 30, I became pregnant for the first time in my life. This did nothing to change the attitude of my husband or his wife toward me. Still, it brought me an inner calm. In my village, there was no chance of antenatal care. I jealously guarded my pregnancy against all of life's ups and downs.

Then one morning around 10, while I was in the field with my husband, a group of five armed men appeared. They demanded money, but we did not have any. So they declared that we were of no use and that we deserved to die. They blindfolded me, stripped and beat me severely. Then they raped me again and again, one after the other, with my hands and feet tied to stakes. Eventually, they abandoned me there, weak and in terrible pain, and dragged my husband away. I felt wet; there was a large quantity of water and blood leaking from my womb, running down my legs. Terrible abdominal cramps seized me and came with increasing waves of agony the whole night without relief.

The following day, my co-wife, having noted our absence, alerted the villagers. They came to search in the fields and found me there, half dead, groaning in pain. They untied me. Between my legs lay my baby, dead, covered in insects. I was in shock and totally anguished at this blasphemy against God, humanity, against life!

Back in the village, after burying my child, the other mothers suggested I remain seated in water for days at a time. In spite of this, after a week I could not control my bladder at all and was constantly leaking and smelling of urine. This was the second terrible ordeal in my life. Having overcome childlessness, I now had to live with incontinence.

One year later, a team of counselors visited our village and then brought me here to Goma for appropriate care. I soon realized that other women suffer from the same problem. I have just undergone three operations without much improvement. I am still leaking. Now they are proposing to divert the urine into the bowels.

But this is a solution that I cannot accept; it would further decrease the chances of my husband ever accepting me back. After the second operation, I returned to the village to see my people, but my husband rejected me, claiming I had AIDS.

## Discussion Points

1. What are the different forms of trauma that Rehema has suffered?
2. How has she reacted to each of these traumas?
3. Rehema has an important decision in front of her. Although her fistula cannot be repaired, there is another operation that could help her. How might Rehema's psychosocial experience and trauma influence her thinking about this decision?
4. What is the role of the provider in counseling Rehema about this situation, and who should be doing the counseling?
5. If Rehema does not get the operation, what other options does she have? What would be her immediate and long-term needs, and what is the role of the providers in helping her address these needs?

## Supplemental Handout

## Supplemental Handout 2-b

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### Case Study—Northern Uganda

*This case study is based on a story presented at the XVIII FIGO Congress of Gynaecology and Obstetrics. Margaret was abducted by rebel soldiers at age 15 and was forced into sexual slavery. Part of the case study below is taken verbatim from the story of the presentation. However, some aspects have been modified, and the end has been changed to reflect the physical injuries that women and girls with traumatic fistula often experience.*

I am called “Margaret.” I was abducted by rebel soldiers in September 1998 from Palabek Kal Subcounty at the age of 15 during a raid in my village. Both of my parents were killed. I saw it with my own eyes. But they spared me, and I was given to a rebel officer. The man I was given to had two wives. On the first night I was there, he called me to him. I went obediently, expecting him to ask me to do something like take some drinking water. He told me to sit next to him. I obeyed. The two women walked out and left us alone.

He started to feel for my breast, I pushed his hand way in disgust. I was so embarrassed that I wanted to insult him, but my grandmother always told me to respect adults. I knew if I obeyed what my grandmother told me, I would grow up into a good child. Even if she was far away, I could still listen to all that she has been telling me and follow all that I learnt from her.

He raped me three times that night. In the morning, I crawled out of his hut and went to one of his wives. I thought she would console me, but she scolded at me and told me that she was not my mother to nurse me.

I crawled around and boiled some water and nursed myself. My hip joint felt as if it was coming out of its sockets, my private parts were very painful. I could not believe it when, two days later, he called me again and raped me twice. My life went on like this for months.

One day, I decided that I could not endure the torture any longer. I started to plan how to run away from the rebels' camp. It was very risky, but I had to do it. One morning, I woke up before the others, gathered my few belongings and whatever food I could carry, and started to run in the direction of where I thought the nearest town was.

I had been running and hiding all day, but the officer was very angry when he found out I had gone, and he sent three soldiers to look for me. They found me and beat me severely. They said they would teach me a lesson, and they pushed tree branches inside me. Finally, when they were through with the beating, I could not walk or even stand up. They said I was useless and left me.

I stayed two more days in the bush, until an elderly man found me on the way to his fields. He helped me to the health clinic. By then, the urine had already started flowing. I could not stop it, and I had a lot of other injuries. A man at the clinic tried to examine my private parts, but I was scared. I pushed him away and screamed. Everyone around me, all strangers to me, were telling me I had to lie down. All I knew was that I could not trust anyone.

## Discussion Points

1. What are the different forms of trauma that Margaret has suffered?
2. How has she reacted to each of these traumas?
3. Margaret is confronted with a situation that she does not fully understand. To get help for her medical problem, she needs to allow the clinic staff to examine her. How might Margaret's psychosocial experience and trauma influence her thinking about this decision?
4. What is the role of the clinic health care provider in counseling Margaret about this situation, and who should be doing the counseling?
5. Assuming that Margaret allows the clinic staff to examine her and they refer her to the hospital, what would be her immediate and long-term needs at the hospital, and what is the role of hospital health care providers in helping her address these needs?

*Source:* Akullu, H. 2006. Voices from the field: Community research on the experiences of survivors and perpetrators of sexual violence. Presentation at the XVIII FIGO Congress of Gynaecology and Obstetrics. Kuala Lumpur, Malaysia. November 5–10, 2006.

## Supplemental Resource

## Trainers' Resource 2-D

### Sample Values Statements

*The following are values that individuals may have regarding fistula or women with fistula.*

#### NOTE TO TRAINERS

Given that women with traumatic fistula live under the double stigma of the physical conditions associated with fistula and the fact that they have been raped, providers may need to be particularly sensitive to the emotional state of women experiencing traumatic fistula.

Women who have been raped were probably in the wrong place at the wrong time and should have been more careful to avoid being raped.

Traumatic fistulas are actually caused by men, and they should be punished.

Girls who are raped at a young age are psychologically changed and will not develop in the same way as other girls.

Sexual violence is something that happens in war. We cannot avoid it, and some women will be unlucky and get raped.

Women and girls who are raped need to be strong and face their difficulties quietly so that they can get on with their lives.

Most women who have been raped do not want to talk about it, so it is just as well not to ask anything.

Traumatic fistula clients have more problems than women with obstetric fistula.

The parents of young girls with traumatic fistula are at fault for allowing a situation where their daughter has been raped.

When traumatic fistula patients decide to file a case against the perpetrator, it puts the personal security of health care service providers at risk.

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 cannot be caused by rape or sexual violence.

Most obstetric 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.

*Go to page 40 in the obstetric fistula training curriculum (Part B: Activity 5—Training Tip).*

## Supplemental Resource

## Part B, Activity 6—Additional Examples of How Values and Attitudes Can Influence Quality of Care

In this activity, you are to ask the participants a series of questions and lead a discussion intended to identify how providers' values and attitudes can negatively influence the quality of care that they provide. In regard to traumatic fistula, trainers should keep in mind several additional points/examples:

- Not offering traumatic fistula clients adequate psychosocial support or referrals because providers believe that it is beyond the scope of health services and that women should find more help on their own if they need it.
- Alienating women and potentially jeopardizing the likelihood that they will seek care, by:
  - Implying that the woman is responsible for the traumatic fistula because she is in some way to blame for the rape
  - Expressing surprise that a young girl has suffered a traumatic fistula and wondering where her parents were when this happened to her
- Not including husbands/partners or other family members in care for women with fistula, because of the belief that women are so embarrassed about the fistula and ashamed about sexual violence that they will not want to talk about the problem with anyone.

*Return to page 41 in the obstetric fistula training curriculum—Step 2 in Part B, Activity 6.*





## Session 3

# Understanding Obstetric and Traumatic Fistula

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Session 3 of *Counseling the Obstetric Fistula Client: A Training Curriculum* defines obstetric fistula, describes the experiences of women with obstetric fistula, explains the etiology of, contributing factors to, and consequences of obstetric fistula, and describes the three elements of a comprehensive strategy for preventing obstetric fistula. Integrating traumatic fistula into this material will require more effort on the part of trainers than simply omitting the word “obstetric” when discussing fistula; a great deal of factual material on traumatic fistula will need to be added.

To integrate the traumatic fistula information into this session, refer to the following elements in this supplement (as directed in the blue box instructions in the obstetric fistula training curriculum):

- Alternative Session 3 Overview: Session Objectives, Points to Remember, Training Methods, Materials, and Advance Preparation (pages 38–40)
- Alternative Activity: Part A, Activity 1: True/False Statements (page 41)
- Supplemental Handout 3-a—Description of the Problem of Traumatic Fistula (pages 42–46)
- Supplemental Resource: Part A, Activity 4: “Victim” versus “Survivor” (page 47)
- Supplemental Handout 3-b—Causes of Traumatic Fistula (pages 48–51)
- Supplemental Handout 3-c—Health and Social Consequences of Traumatic Fistula (pages 52–54)
- Supplemental Activity: Additional Part C, Activity 2: Consequences of Traumatic Fistula (page 55)
- Supplemental Handout 3-d—Consequences of Traumatic Fistula at the Individual, Family, and Community Levels (page 56)
- Supplemental Resource: Part D—Additional Points to Discuss (page 57)

## Alternative Session 3 Overview

## Session 3 Overview

### Session Objectives

During this session, the participants will:

- Define obstetric fistula and traumatic fistula
- Contrast the experiences of women with obstetric fistula and traumatic 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 type of fistula is 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" (Wall, 1998).
- ✓ 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:
  - Delaying pregnancies
  - Improving access to obstetric care, including emergency care
  - Addressing social issues
- ✓ A **traumatic fistula** is an abnormal opening between the reproductive tract of a woman or girl and one or more body cavities or surfaces, caused by sexual violence, usually but not always in conflict and postconflict settings.

(continued)

## POINTS TO REMEMBER (continued)

- ✓ Sexual violence is defined as “any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work.” Sexual violence includes systematic rape during armed conflict (WHO, 2002).
- ✓ Traumatic fistula can occur as the result of multiple rape, gang rape, or particularly brutal sexual violence, which may include the insertion into the vagina of weapons (e.g., guns, bayonets, and knives), sticks or tree branches, nails, or other sharp objects.
- ✓ Traumatic fistula can occur to women and girls of any age. Young girls may experience third-degree and fourth-degree tears of the perineum as a consequence of sexual violence, with consequences similar to or worse than what is defined as traumatic fistula.
- ✓ While traumatic fistula is considered to be fistula caused by sexual violence, women can also develop fistula as a result of other causes, such as gynecological operations (iatrogenic), harmful traditional practices, and disease (e.g., rectal carcinoma, Crohn’s disease, or cervical cancer radiation treatment).
- ✓ Harmful traditional practices that can lead to fistula include female genital cutting and infibulation (such as the *gishiri* cut). In these cases, the affected areas have been physically traumatized, though not through rape.
- ✓ Women and girls with traumatic fistula are at risk of two forms of psychosocial stress directly related to their condition: stress from isolation, shame, and stigma associated with fistula; and isolation, shame, and stigma associated with the sexual violence incident(s) that caused the fistula. Depending on their own situation (e.g., their individual resilience, personal characteristics, or level of available support), women and girls with traumatic fistula may suffer from a variety of stress symptoms, including feelings of guilt and/or shame, anger, anxiety, numbness, social withdrawal, nightmares or other difficulties sleeping, substance abuse, and suicidal thoughts.
- ✓ The three components of psychosocial support to survivors of sexual violence are emotional support, case management, and rehabilitation/social reintegration (IASC Sub-Working Group on Gender & Humanitarian Action. 2008, pp. 26–27).

## 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
- Supplemental Participant Handout 3-a: Description of the Problem of Traumatic Fistula
- Supplemental Participant Handout 3-b: Causes of Traumatic Fistula
- Supplemental Participant Handout 3-c: Health and Social Consequences of Traumatic Fistula
- Supplemental Participant Handout 3-d: Consequences of Traumatic Fistula at the Individual, Family, and Community Levels

## 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 Time (total): 1 hour, 55 minutes*

*Return to page 69 in the obstetric fistula training curriculum—Session 3 Training Steps.*

## Alternative Activity

## Part A, Alternative Activity 1: True/False Statements

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
Traumatic fistula can occur to women and girls at any age.	True
Traumatic fistula never occurs outside of conflict settings.	False
Traumatic fistula is as common as obstetric fistula overall.	False

Review the correct answers and highlight the following points:

- *Traumatic fistula can occur to women and girls at any age.*  
Fistula caused by sexual violence in young girls can differ somewhat from fistula in grown women, in that young girls often suffer third- or fourth-degree tears of the perineum. However, the effect is the same, if not worse. In some instances, girls requiring repair surgery for traumatic fistula must wait until tissues in the affected area have sufficiently matured for the operation to be successful.
- *Traumatic fistula never occurs outside of conflict settings.*  
Although most cases of traumatic fistula have been documented in connection with women and girls living in affected by conflict, sexual violence—and therefore traumatic fistula—can occur anywhere.
- *Obstetric fistula is more common than traumatic fistula.*  
In some settings, during periods of intense conflict, the incidence of traumatic fistula may be high. However, in general, the majority of fistula cases are related to obstructed labor. All girls and women suffering from fistula—regardless of the cause—require skilled professional assistance to heal both the physical and the emotional consequences of their condition.

*Return to page 69 in the obstetric fistula training curriculum—Part A: Activity 2.*

## Supplemental Handout

## Supplemental Handout 3-a

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### Description of the Problem of Traumatic Fistula

Traumatic gynecologic fistula (referred to as traumatic fistula) is “an abnormal opening between the reproductive tract of a woman or girl and one or more body surfaces, caused by sexual violence, usually but not always in conflict and postconflict settings” (Addis Ababa Fistula Hospital et al, 2006). Although the definition highlights conflict settings, it is recognized that sexual violence also occurs within nonconflict settings and can even occur within domestic relationships. When sufficiently severe, sexual violence can lead to traumatic fistula, regardless of the setting.

Sexual violence can lead directly to tears in the perineum—the area between the vagina and the anus. The most superficial, known as first-degree tears, involve the skin of the perineum and the tissue around the opening of the vagina or the outermost layer of the vagina itself, but not any muscles. Second-degree tears extend into the muscles beneath the skin. A third-degree laceration is a tear in the vaginal tissue, the perineal skin, and the perineal muscles that extends into the anal sphincter (the muscle surrounding the anus, while a fourth-degree tear goes through the anal sphincter and the tissue underneath it.

### The Magnitude of Traumatic Fistula

Despite the significant and visible challenges posed by traumatic fistula for those women and girls who suffer with the condition, it is in many ways a hidden problem. The severe stigma associated with rape in many societies, in addition to the isolating effect of fistula symptoms, can hinder women and girls from coming forward to seek treatment, especially if they are unaware that treatment exists. As well, those needing medical care may live too far from services to easily access them even if they are available. Hospital or fistula clinic counts, which are typically used to measure magnitude, are only able to capture data for those women and girls whom they are able to help; clinics cannot measure the cases of those who never come for treatment. Women and girls who do reach help do not always feel comfortable sharing information about sexual violence with providers, and the underlying cause of the fistula may become clear only with active questioning by the medical staff. As well, cases classified as obstetric fistula may in fact be due to complications at delivery of an infant conceived from sexual violence. This may further confuse any available statistics. Following below are statistics from the Democratic Republic of Congo (DRC), Liberia, and Sudan, where statistics are most readily available. These figures likely capture only a small portion of all women and girls who are affected by traumatic fistula in conflict and postconflict settings around the world.

#### *Democratic Republic of Congo*

Estimates of traumatic fistula, as a proportion of all fistula cases, vary according to location, definition used, and time period.

- Longombe, Kasereka, and Ruminjo, referencing a report of 4,715 sexual violence survivors who were received at what was then the Doctors on Call for Service/Heal Africa Hospital (currently the Heal Africa Hospital) in Goma between April 2003 and June 2006, note that 17.5% suffered from genital

fistula. Of all the fistula patients, 63.4% had experienced traumatic fistula, and 36.6% were due to obstetric causes (Longcombe, Kasereka, & Ruminjo, 2008).

- The Panzi General Referral Hospital (Panzi Hospital) defines traumatic fistula as any fistula that occurs as a direct result of rape and which is not related in any way to obstetric or iatrogenic causes. According to a review of hospital records covering the period November 2005 to November 2007, researchers report that 4% were reported as caused by sexual violence (Onsrud et al., 2006).
- The Maternité Sans Risque Hospital has offered assistance to sexual violence survivors in Maniema Province in central DRC since 2000. During the period March 2002 through December 2007, medical staff at the Kindu-based hospital treated 341 traumatic fistula cases due to sexual violence. As reported elsewhere, the proportion of fistula cases due to sexual violence, compared with obstetric and other causes, fluctuates according to the level of insecurity. At this location, 2003 is noted as the worst year, when it is estimated that 70–80% of all fistula cases could be classified as due to sexual violence.<sup>1</sup>

### *Liberia*

In 2006, the United Nations Population Fund (UNFPA) and partners in Liberia conducted a study of 48 medical centers in Liberia throughout four counties (Lofa, Bong, Nimba, and Montserrado), in which they found that of 351 fistula repair surgeries between January 2004 and December 2005, 13% were traumatic fistula cases, though this was defined to include both rape-related fistula and fistula due to iatrogenic causes (Mulbah, 2006; Mulbah, 2008).

### *Sudan*

UNFPA has estimated that in early and mid-2000s, there were 5,000 new fistula cases per year in Sudan, though it is unclear how many women suffer from traumatic fistula. That more than 60% of fistula cases are believed to occur in conflict-affected Western Darfur is, however, a likely indication of a significant traumatic fistula burden (UNFPA, 2007). In early 2008, the Office of the United Nations High Commissioner for Refugees (UNHCR) reported that two-thirds of the Sudanese refugee women receiving fistula treatment at the Abeche Regional Hospital in eastern Chad had been raped by Janjaweed militiamen (UNHCR, 2005).

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<sup>1</sup> Information provided by Manga Okenga, Maternité Sans Risque Hospital, Kindu, DRC, in in-person informational interview, June 21, 2008. Kampala, Uganda. Traumatic fistula treatment and counseling at the Maternité Sans Risque Hospital.

## Types of Fistula

There are several types of fistula—broadly divided between urinary fistula and fecal fistula. Although classifications of fistula remain a subject of debate at the international level, for the purposes of this curriculum, the following descriptions are offered.

- 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 **vesico-uterine 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 **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.

In general, 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. Data available for traumatic fistula specifically are limited to the Democratic Republic of Congo, as presented below:

- According to a review of clinical records from 2003–2006 at Heal Africa Hospital, 87% of all fistula repair cases were vesicovaginal, 6% were rectovaginal, and 6% were combined rectovaginal and vesicovaginal. These include both traumatic and obstetric, with the percentage of each varying significantly by year, from 75% traumatic and 25% obstetric in 2004 to 20% traumatic, 68% obstetric, and 12% surgery-related in 2006 (Kalume & Ahuka, 2008).
- At Panzi Hospital, a review of clinical records for the period November 2005 to November 2007 noted that of five fistula cases directly related to sexual violence, two were vesicovaginal, two were rectovaginal, and one was urethrovaginal. For the 13 additional cases that were indirectly related to sexual violence, nine were vesicovaginal, three were urethrovesicovaginal, and one was vesico-uterine (Onsrud et al., 2008).

Information from clinics in conflict-affected Liberia and Somalia highlight the following statistics on fistula cases:

- At the Galkayo Medical Center in central Somalia, an unusual proportion of fistula (mainly obstetric) were reported to be rectovaginal, due to hard scar tissue around the vulva that develops as a result of infibulation. During child delivery, this causes the perineum to collapse and leads to rectovaginal fistula (Giama, 2008).
- In Liberia, where traumatic fistula was estimated to represent 13% of all fistula cases in a 2007 survey, a national fistula project was launched in April 2007. By June 2008, 189 fistula surgeries had been completed, of which the majority (81%) were vesicovaginal only, 3% were rectovaginal, and 2% were combined rectovaginal and vesicovaginal (Mulbah, 2008).



## References

- Addis Ababa Fistula Hospital, EngenderHealth/The ACQUIRE Project, Ethiopian Society of Obstetricians and Gynecologists, and Synergie des Femmes pour les Victimes des Violences Sexuelles. 2006. *Traumatic gynecologic fistula: A consequence of sexual violence in conflict settings—A Report of a Meeting Held in Addis Ababa, Ethiopia, September 6 to 8, 2005*. New York: EngenderHealth/The ACQUIRE Project.
- Giama, A. 2008. Obstetric fistula management in conflict zones. Presentation at the RAISE Reproductive Health in Emergencies Conference, June 20, 2008, Kampala, Uganda.
- Kalume, J., and Ahuka, A. 2008. La prise en charge des fistules génitales de la femme end RDC : contexte, ampleur, et perspectives. Presentation at the RAISE Reproductive Health in Emergencies Conference, June 20, 2008 . Kampala, Uganda.
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- Mulbah, J. 2006. *Situation analysis of obstetric fistulae in Liberia*. Monrovia, Liberia: The Liberia Ministry of Health and Social Welfare and United Nations Population Fund.
- Mulbah, J. 2008. Fistula: A symptom of women's vulnerability in conflict and post-conflict setting. Presentation at the RAISE Reproductive Health in Emergencies Conference, June 20, 2008, Kampala, Uganda.
- Onsrud, M., Sjøveian, S., Luhiriri, R., and Mukwege, D. 2008. Sexual violence-related fistulas in the Democratic Republic of Congo. *International Journal of Gynecology and Obstetrics* 103(3):265–269.
- United Nations Office of the High Commissioner for Refugees (UNHCR). 2005. *UNHCR, UNFPA fund surgery for refugee and local women in Chad*. Retrieved from <http://reliefweb.int/rw/rwb.nsf/db900sid/HMYT-6AKPQ3?OpenDocument&query=fistula>, June 2, 2008.
- United Nations Population Fund (UNFPA). 2007. UNFPA Frontlines: notes from the field. The Humanitarian Response Newsletter, retrieved from <http://www.unfpa.org/emergencies>, May 30, 2008.



## Supplemental Activity

### Part A, Additional Activity 4: “Victim” vs. “Survivor”

It is important for training participants to understand that how they address or describe women with traumatic fistula can be critical. Therefore, included below is an additional activity that aims to help participants understand why it is preferable to refer to women with traumatic fistula as “survivors” rather than as “victims.”

#### Activity 4: Small-Group Work (15 minutes)

1. Divide the participants into two groups. Ask one group to write on a piece of flipchart paper as many words as possible to describe a “victim” of sexual violence. Ask the other group to write on a piece of flipchart paper as many words as possible to describe a “survivor” of sexual violence.
2. 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 on or make additions to what has been presented.
4. If necessary, supplement the lists after all of the groups have presented their results.

#### TRAINING TIP

There is a difference in using the term “survivor” as opposed to “victim.” The word “victim” brings to mind someone who is weak, sick, small, helpless, and unable to function. In contrast, one thinks of a “survivor” as being someone strong, confident, unafraid, and able to overcome difficulties. “Victim” is a disempowering word, whereas “survivor” is empowering. It is important to refer to individuals who have experienced sexual violence as survivors and not as victims.

*Adapted from:* Vann, 2004.

*Return to page 70 in the obstetric fistula training curriculum—Part B: Causes of Obstetric Fistula.*

## Supplemental Handout

# Supplemental Handout 3-b

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## Causes of Traumatic Fistula

Among the several distinct *direct* causes of gynecologic fistula, such as fistula caused by obstructed labor (obstetric fistula), fistula caused by accidental surgical injury, and fistula caused by disease, is fistula caused by extreme sexual violence and direct injury to the genito-urinary tract (traumatic fistula). In the case of traumatic fistula especially, it is important to consider *underlying* causes as well.

### Traumatic Fistula

Sexual violence is not the most common cause of fistula. However, traumatic fistula is one of the most serious outcomes of sexual violence in conflict situations. Traumatic fistula does not occur in all cases of rape; rather, it is caused through particularly violent rape, involving penetration of the vagina, the rectum, or both. Typically, traumatic fistula occurs in connection with rape by multiple assailants and/or the use of sharp objects and/or the firing of weapons in the vagina. Knives, rifles, wooden sticks, branches and dried wood, construction nails, pipes, and other sharp implements are sometimes used (Manga Okenge, 2008). In cases of traumatic fistula, internal injuries can result in a hole between the woman's vagina and bladder (*vesicovaginal fistula* [VVF]) or between her vagina and rectum (*rectovaginal fistula* [RVF]), or both.

### *Underlying Social Causes of Traumatic Fistula*

The most important underlying social cause of traumatic fistula is war and the use of sexual violence as a weapon of war. In recent decades, efforts to focus attention on the impact of war on women and girls have increased, and rape as a weapon of war has been documented in a number of recent and current conflicts, from the Democratic Republic of Congo (DRC), Rwanda, and Sierra Leone, to Burma/Thailand, East Timor, and Kosovo. More recently, much attention has been focused on the widespread and systematic rape of women and girls by warring parties in the DRC, particularly in the eastern and central regions, and the resulting cases of traumatic fistula. (See also Handout 2A for further details.)

Although it has been argued that sexual violence has always been part of conflict, recent years have seen a systematic increase in the efforts of professionals in the medical, legal, human rights, and other fields to address the prevention of sexual violence in general and in conflict situations specifically. In June 2008, members of the United Nations Security Council unanimously adopted Resolution 1820, which recognizes that women and girls are sometimes targeted for sexual violence as a tactic of war and demands the complete and immediate halt to acts of sexual violence. The United Nations Secretary General is responsible for reporting on implementation of the resolution. Although implementation of this resolution will be challenging, its adoption marks an important global, policy-level effort to address sexual violence, and efforts in this direction should impact the underlying cause of traumatic fistula.

Many actors in government services, nongovernmental organizations, and civil society movements are actively seeking to eliminate sexual violence. Those in the medical field play a key role in these efforts. At the bottom of this handout, you will find a listing of additional references and resources that provide more

detail on current efforts to address the direct and underlying causes of traumatic fistula and sexual violence. Session 9 (Supporting the Fistula Client) describes in more detail how community-level efforts work to address the issues of sexual violence and traumatic fistula.

### *Underlying Social Issues that Increase the Burden of Traumatic Fistula*

While sexual violence is the main direct cause of traumatic fistula, other underlying social issues may make it difficult for women and girls to access the care they need. Among 24 fistula cases directly or indirectly related to sexual violence at Panzi Hospital (Bukavu, Democratic Republic of Congo), one-third of the women accessed treatment a year or more after the fistula had developed (Onsrud et al., 2008). There are several reasons for delayed treatment, as described below. These delays contribute to the overall burden of traumatic fistula borne by individuals, families, and communities in conflict situations.

1. **Lack of local services:** The health care services available to populations in remote villages affected by conflict are often minimal in the best of circumstances. During periods of conflict, health care systems at all levels are often targeted for destruction. Local health clinics are frequently looted, and personnel may be forced to leave their posts due to very real concerns for their own safety. Fistula repair surgery is usually carried out at centrally located, specialized clinics where specialists and the necessary clinical equipment and supplies are available. In most cases, women and girls suffering from traumatic fistula cannot access the help they need locally.
2. **Lack of information:** In some situations, women and girls with traumatic fistula may not be aware that a procedure for fistula repair exists. Even if they have hope for a surgical response to their condition, they may not be aware of services available in their general area. Many of the hospitals and clinics that offer fistula repair have established outreach services to let populations know that help exists, and they support women and girls with this condition to access help through mobile surgical units and/or referral and transportation support.
3. **Stigma:** Women and girls with traumatic fistula suffer the double burden of stigma due to the medical condition of fistula (which can lead to isolation by others and/or self-isolation) and the stigma due to rape. Sexual violence survivors in many societies are themselves blamed for being raped and may carry strong feelings of guilt and shame that prevent them from seeking help.
4. **Insecurity:** Even if individuals with traumatic fistula are aware that repair surgery is possible, know where to find it, and are able to overcome the stigma associated with their condition, many will face real challenges in accessing services due to insecurity. They may live in communities that are cut off from other locations due to ongoing conflict and may be unable to travel to fistula repair sites without risking their lives and well-being.

### **References**

Manga Okenge, P. 2008. Les fistules traumatiques non accidentelles et non chirurgicales dues à la violence sexuelle en RD Congo. Presentation at the RAISE Reproductive Health in Emergencies Conference, June 20, 2008, Kampala, Uganda.

Onsrud, M., Sjøveian, S., Luhiriri, R., and Mukwege D. 2008. Sexual violence-related fistulas in the Democratic Republic of Congo. *International Journal of Gynecology and Obstetrics*. 103(3):265–269.

## **Additional References and Internet Resources on Traumatic Fistula and Conflict-Related Sexual Violence**

The following is a partial listing. For a more complete bibliography, please refer to: EngenderHealth. 2009. *Traumatic gynecologic fistula as a consequence of sexual violence in conflict settings: Updated literature review*. New York.

Achwal, I., Ruminjo, J., and Ngongo, C. 2008. Traumatic gynecologic fistula in reproductive health emergencies. Presentation at the RAISE Reproductive Health in Emergencies Conference, June 20, 2008, Kampala, Uganda.

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Peterman, A., and Johnson, K. 2009. Incontinence and trauma: Sexual violence, female genital cutting and proxy measures of gynecological fistula. *Social Science and Medicine* 68(5):971–979.

Pinel, A., and Kemunto Bosire, L. 2007. Traumatic fistula: The case for reparations. *Forced Migration Review* (27):18–19.

## **Internet web sites with additional resources related to sexual violence in conflict and/or fistula**

**Campaign to End Fistula**—[www.endfistula.org](http://www.endfistula.org)

**Fistula Care Project**—[www.fistulacare.org](http://www.fistulacare.org)

**Fistula Network**—[www.fistulanetwork.org/FistulaNetwork/](http://www.fistulanetwork.org/FistulaNetwork/)

**Gender-Based Violence Network**—[www.gbvnetwork.org/](http://www.gbvnetwork.org/)

**GBV Working Group, UNFPA and UNICEF**—[www.humanitarianreform.org/Default.aspx?tabid=429](http://www.humanitarianreform.org/Default.aspx?tabid=429)

**Heal Africa Hospital**—[www.healafrika.org/cms/](http://www.healafrika.org/cms/)

**InterAgency Standing Committee**—

[www.humanitarianinfo.org/iasc/pageloader.aspx?page=content-subsidi-tf\\_gender-gbv](http://www.humanitarianinfo.org/iasc/pageloader.aspx?page=content-subsidi-tf_gender-gbv)

**Joint Consortium on Gender Based Violence**—[www.gbv.ie/](http://www.gbv.ie/)

**Panzi General Referral Hospital**—[www.panzihospitalbukavu.org/](http://www.panzihospitalbukavu.org/)

**UNIFEM Say NO to Violence Against Women Campaign**—[www.unifem.org/campaigns/vaw/](http://www.unifem.org/campaigns/vaw/)

**UN Action Against Sexual Violence in Conflict: Stop Rape Now**—[www.stoprapenow.org/](http://www.stoprapenow.org/)

**VDAY, Stop Rape Now, UNICEF: Stop Raping Our Greatest Resource. Power to Women and Girls of Democratic Republic of Congo**—[www.stoprapeindrc.org/index\\_40.html](http://www.stoprapeindrc.org/index_40.html)

## Supplemental Handout

# Supplemental Handout 3-c

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## Health and Social Consequences of Traumatic Fistula

Traumatic fistula can be devastating. Not only does the afflicted woman or girl suffer the trauma of being brutally raped, but the lasting physical consequences of the fistula—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 her health and well-being that can result in early death. Some women with fistula commit suicide.

The wide range of adverse medical and social consequences has serious 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” (Wall, 1998).

## Medical Consequences of Traumatic Fistula

- 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 fistula are socially isolated and may not receive adequate nutrition or may be obliged to beg for food.
- The genital tract may be scarred and lead to dyspareunia (pain during sexual intercourse).

## Other Medical Consequences of Sexual Violence

- Women and girls of reproductive age who have been raped can become pregnant—a common concern of sexual violence survivors. If the client comes for treatment within five days of the rape, it is possible to prevent pregnancy through emergency contraception. In most cases, however, the delay in reaching health care is much longer, and clients who may have become pregnant as a result of the rape face the situation of undesired pregnancy, with the additional stigma of bearing a child born of rape. There is a risk that the child will be rejected by the mother and/or her family.
- Pregnancy due to rape may also result in a fistula. In this way, some obstetric fistula cases may in fact be indirectly caused by sexual violence. Though not technically a traumatic fistula, this is a possible outcome of sexual violence.
- Sexual violence survivors of all ages are at risk of transmission of sexually transmitted infections (STIs) and HIV. This is another common concern among traumatic fistula clients. Although the risk of transmission with any one particular sexual exposure is small, it is of particular concern in settings where the prevalence of STIs and HIV is high (WHO & UNHCR, 2004). The possible transmission of STIs and HIV is a concern not only for the sexual violence survivor, but also for her partner, and this can be a contributing factor to abandonment.



- Women and girls who have been sexually assaulted may also suffer from a wide range of other physical injuries, including both superficial wounds that can cause significant discomfort during healing (such as bruises, bite marks, scratches, and other surface injuries) and/or other physical injuries that require immediate and special care (such as deep cuts and lacerations, broken bones, internal wounds, etc.).

## Social Consequences of Traumatic Fistula

- **Stigma due to rape:** In many societies, sexual violence survivors are blamed by others for rape and/or may themselves feel responsible for the situation. Women and girls who have been raped may be perceived as dirty and/or damaged and may be stripped of their dignity and female identity. Many sexual violence survivors feel intense shame, and this is frequently a reason for delay in seeking treatment.
- **Social isolation due to fistula:**
  - Women with fistula may be perceived as dirty, and thus they are often excluded, or they may exclude themselves, from participating in community activities, including religious celebrations or public observances.
  - Adolescents and girls living with fistula may experience reduced opportunities for education, work, marriage, and community participation (Mungherera, 2009).
  - Incontinence and stigma related to rape 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.
  - Some traumatic fistula clients are also pregnant as a result of conflict-related rape. The stigma of pregnancy by rape can be another cause of social isolation (Kalume & Longombe, 2008).
  - 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 being unable to make a living by themselves, many women with fistula live for years without any financial support. Many fall into extreme poverty.
  - Some women cannot cope with the pain and suffering and resort to suicide.

## References

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**Supplemental Resource****Part C, Additional Activity 2: Consequences of Traumatic Fistula**

Session 3 of *Counseling the Obstetric Fistula Client* concludes with an activity devoted to informing the participants about how both the direct and the indirect causes of obstetric fistula might be prevented. However, before moving on to prevention, a training focused on both obstetric and traumatic fistula should spend some time on raising participants' awareness of the psychosocial impact of traumatic fistula at the individual, family, and community levels.

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

1. Present a brief summary of the consequences of traumatic fistula at the individual, family, and community levels, based on Supplemental Handout 3-d (see next page).
2. Ask one or two participants to describe potential consequences of traumatic fistula at each level (individual, family, and community).
3. Present the content on psychosocial impact of traumatic fistula at each of the three levels, using Supplemental Handout 3-d.
4. Distribute Supplemental Handout 3-d to the participants.

*Return to page 72 in the obstetric fistula training curriculum—Part D: Reasons Why Women Do Not Seek Care.*

Supplemental Handout

## Supplemental Handout 3-d

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### Consequences of Traumatic Fistula at the Individual, Family, and Community Levels

Traumatic fistula and the sexual violence that causes it have a serious impact first and foremost on the individuals affected, but they also affect the survivors' families and the community in general. Health care providers who work with women suffering from traumatic fistula interact with all three levels. Some of the consequences of traumatic fistula at the individual, family, and community levels include the following:

#### Individual level

- Physical impact, including those directly related to traumatic fistula (e.g., incontinence), as well as other possible injuries and disability/inability to work, possible undesired pregnancy, and possible infection with a sexually transmitted infection, including HIV
- Psychosocial impact, including feelings of shame, guilt, grief, anxiety, and depression
- Social isolation
- Abandonment by spouse/partner, or other difficulties with spouse/partner
- Economic vulnerability
- Continued concerns about physical safety

#### Family level

- Trauma to family members who may have been forced to watch the rape of the individual or who were otherwise directly or indirectly affected by the violence
- Husband's and/or other family members' feelings of powerlessness in not having been able to prevent the rape
- Health risks to children if the individual is unable or not allowed to care for them directly
- Stress on other family members caring for the individual and/or her children

#### Community level

- Community feelings of guilt and powerlessness at having been unable to protect women and girls living in the community, and continued concerns about security
- Strain on local health services that may not be able to adequately respond to health needs, as well as other community services (legal systems, protection, social welfare)
- Secondary trauma to those in the community who support sexual violence survivors (e.g., local health care providers, social workers, etc.)

*Adapted from: CARE. 2002. Moving from emergency response to comprehensive reproductive health programs: A modular training series. Atlanta.*

## Supplemental Resource

**Part D, Additional Points to Discuss**

Part D of Session 3 examines why women with fistula often do not seek care. With respect to traumatic fistula, many of the reasons why women do not seek care are the same as those related to obstetric fistula—they may not be aware of a possible cure, they may lack access to health facilities, they may not believe in modern health care or trust health care services, local health facilities may be unwilling to care for fistula clients, or there may be no skilled providers. In addition, living with traumatic fistula presents enormous physical and psychological challenges to the women and girls who have the condition, and there are reasons related to both fistula repair and sexual violence why they may not seek help.

The following points highlight several ways in which the special circumstances of traumatic fistula may prevent those who need help from getting it (Kalyango, 2009).

- They may fear the stigma attached to being a victim of violence, especially rape
- There may be a history of negative outcomes following disclosure of sexual violence in the community
- They may fear retribution from an offender, especially if the perpetrator of sexual violence is known to the victim.

It is also important to emphasize that women's lack of access to health facilities due to distance, time, and cost can also have a component related to the threat of sexual violence: Women and girls suffering from traumatic fistula typically live in conflict areas. Many times, the same lack of security that causes the problem is a hindrance in being able to access services (Mugerwa, 2009).

Another point that the trainers should try to communicate is that because health care workers may have had limited opportunities to learn about the special needs of sexual violence survivors, they may have difficulty showing empathy for traumatic fistula clients.

*Return to page 72 in the obstetric fistula training curriculum—Part E: Prevention of Obstetric Fistula.*



## Session 4

# Understanding the Client's Perspective

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In Session 4 of *Counseling the Obstetric Fistula Client*, workshop participants are encouraged to discuss the characteristics of women with fistula and the situations or conditions that lead clients to seek repair of an obstetric fistula, develop case studies to be used in subsequent role-plays, describe how to work with fistula clients sensitively and respectfully, and explore how cultural attitudes about gender may affect the treatment that fistula clients receive.

The foremost challenges in adapting that curriculum to include traumatic fistula are helping service providers to appreciate issues related to the added psychological stress and traumatization that affect women exposed to sexual violence and to understand the role they can play in helping clients to perceive themselves as *survivors*. In many settings and cultures, women and girls who have experienced sexual violence have a great sense of shame and guilt, due to the tremendous stigma surrounding rape. In addition, they may have been cast out from their homes and communities because of their medical condition. Clients may feel isolated, ashamed, worried about their future, and frightened that they will be raped again when they return to their communities, if conflict is ongoing.

To integrate the traumatic fistula information into this session, refer to the following elements in this supplement (as directed in the blue box instructions in the obstetric fistula training curriculum):

- Alternative Session 4 Overview: Session Objectives, Points to Remember, Training Methods, Materials, and Advance Preparation (pages 60–64)
- Supplemental Resource: Supplement 4A, Part A: Overview of Mental Health, Stressors, and Protective Factors (pages 65 and 66)
- Supplemental Handout 4-a: Overview of Mental Health, Stressors, and Protective Factors (pages 67–69)
- Supplemental Resource: Supplement 4B, Part B: The Psychosocial Response to Sexual Violence and Traumatic Fistula (pages 70 and 71)
- Supplemental Handout 4-b: Psychosocial Response to Sexual Violence and Traumatic Fistula (pages 72–74)
- Supplemental Resource: Additional Training Considerations for Developing Case Studies (pages 75 and 76)
- Supplemental Resource: Additional Information Regarding Confidentiality, Privacy, and Dignity (page 77)

## Alternative Session 4 Overview

# Session 4 Overview

## Session Objectives

As a result of this session, the participants will be able to:

- Define symptoms of psychological stress related to sexual violence and fistula
- Share reasons why women may not seek care for fistula and/or other health issues related to sexual violence
- Describe how sexual violence survivors may feel retraumatized by a medical examination
- 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
- Explain how information provided during medical consultations (and the choices clients may face as a result) can overwhelm women, and explore ways to appropriately counsel clients on medical issues
- 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
- Explain the importance of supporting clients' resilience and helping clients to recognize themselves as survivors

## 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
- ✓ There are several reasons why clients may delay in seeking care for traumatic fistula: They may lack information about the availability of services; there may be no reliable transport to a source of services; physical security for the women may be lacking; and the women may not be confident in the health services available. *(continued)*



**POINTS TO REMEMBER (continued)**

- ✓ Women and girls with traumatic fistula are subject to the combined psychological stress of both the fistula condition and sexual violence. Both factors can lead these women to be isolated by others and/or to isolate themselves by their own actions.
- ✓ Clients may experience a variety of problems stemming from the psychosocial impact of sexual violence:
  - Emotional responses (e.g., anxiety, social isolation, sudden mood shifts, irritability, grief, depression, feeling overwhelmed, or feelings of fear, guilt, and shame)
  - Cognitive responses (e.g., reliving the experience, nightmares, hypervigilance, poor problem-solving ability, loss of orientation, or problems with memory, concentration, and attention)
  - Physical responses (e.g., shock symptoms, dizziness, headaches, difficulty breathing, muscle tremors, hyperarousal, fatigue, vomiting/nausea, and insomnia)
  - Behavioral responses (e.g., withdrawal, heightened startle reaction, increased or decreased appetite, acting out, pacing, substance abuse, and homicidal or suicidal actions)  
(Adapted from: FHI, RHRC Consortium, & IRC, no date)
- ✓ Women and girls who seek traumatic fistula repair services may not readily discuss sexual violence due to one or several of the following fears:
  - Fear of further isolation from family and community networks, even if the physical problem of fistula is addressed
  - Fear of stigmatization by health care staff and/or concerns about confidentiality
  - Fear of physical examination
  - Fear of personal security repercussions  
(Adapted from: Pickup, Williams, and Sweetman, 2001)
- ✓ Clients may be overwhelmed by the range of medical consequences (incontinence, possibility of infection with HIV or some other sexually transmitted infection, possibility of unwanted pregnancy, possibility of later problems in childbearing).
- ✓ Clients may have doubts and fears about the fistula repair surgery, including the fear of being further damaged in the process, which can manifest itself through hostility.
- ✓ Different clients may have different perspectives or needs, depending on their circumstances, and thinking about the best approach to counseling, providers should consider the following:
  - Demographic and social characteristics, including ethnicity, marital status, parity, job status, and access to resources and support
  - Situations (recent vs. long-term condition; stillborn versus live birth, if resulted in pregnancy)
  - Phase of treatment
  - Level of available support (i.e., if a young girl, whether accompanied by the mother or orphaned; if married, whether supported by or rejected by her husband; whether rejected by other family members or not rejected)

*(continued)*

## POINTS TO REMEMBER (continued)

- ✓ The perspective of traumatic fistula clients may differ by age. Younger women may be more concerned about the future consequences of their condition, especially their ability to marry, bear children, and work; older women may focus more on the impact of the sexual violence incident on their role in the community and on issues related to their reintegration. Counselors should be sensitive to the needs of individual clients and recognize that different women may have different perspectives, depending on their situation.
- ✓ Psychological needs can arise some time after the traumatic incident. Even if clients do not express a need for psychosocial assistance at the time of services, staff should recognize that mental health wounds may take longer to heal than physical injuries, and they should offer referral and information about services within the clinic or through partner organizations (*adapted from: WHO, 2005*).

## 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
- Supplemental Participant Handout 4-a: Overview of Mental Health, Stressors, and Protective Factors
- Supplemental Participant Handout 4-b: The Psychosocial Response to Sexual Violence and Traumatic Fistula
- Participant Handout 4-A: Ensuring Clients' Confidentiality, Privacy, and Dignity
- Participant Handout 4-B: Gender
- Participant Handout 4-C: Sexuality
- DVD—*Clinical Care for Sexual Assault Survivors: A Multimedia Training Tool*

## 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 titled “Demographic and Social Characteristics” and one titled “Social Situations and Emotional and Physical Conditions.”
6. Prepare the following flipchart (for Part B, Activity 2):

*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

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 titled “Addressing the Client's Feelings” and should have three columns: “Client's Feelings,” “Why?” and “Provider's Response” (see sample on page 64, and see Trainer's Resource 4-A for a sample completed flipchart).

*Addressing the Client's Feelings*

Client's name: \_\_\_\_\_

Client's Feelings	Why?	Provider's Response

*Session Time (total): Option 1: 4 hours, 35 minutes; Option 2: 3 hours, 30 minutes*

*Go to page 92 in the obstetric fistula training curriculum—Session 4 Training Steps.*

## Supplemental Resource

# Supplement 4A

## NOTE TO TRAINERS

Supplement 4A is designed to help participants understand the perspectives of clients who have suffered sexual violence and traumatic fistula.

## PART A: Overview of Mental Health, Stressors, and Protective Factors

*Time: 20 minutes*

### Activity 1: Discussion (20 minutes)

1. Ask the participants to take a piece of paper and write down their own definitions of the terms *mental health*, *stressors*, and *protective factors*.
2. Ask for volunteers to offer their own definitions for each of these terms, and write down some of the key ideas on a piece of flipchart paper.
3. Distribute Supplemental Handout 4-a: Mental Health, Stressors, and Protective Factors.
4. Facilitate a discussion examining mental health, stressors, and protective factors, based on the participants' definition of these terms and references to the handout.

## TRAINING TIP

Although this session mainly addresses the importance of providers' understanding the perspectives of clients who have suffered sexual violence and traumatic fistula specifically, it can be helpful to place these perspectives within a broader framework of understanding mental health in conflict situations. Women and girls in these circumstances may have been living with stressors and changing protective factors associated with conflict, even before the rape that caused traumatic fistula. During the discussion in Activity 1, remind the participants that some of the general stressors frequently associated with conflict include:

- Displacement (i.e., living in internally displaced camps or refugee camps)
- Separation from family members
- Exposure to military insecurity and direct combat
- Limited access to health services, food, water, and shelter
- Limited educational and employment opportunities

Source: Mungherera, 2009

*(continued)*

### TRAINING TIP (continued)

It is important for providers to think about the full range of background events that may impact the way in which a client reacts to sexual violence and traumatic fistula. The traumatic fistula client is usually dealing with the *double burden* of rape trauma and a serious medical condition. Both of these situations are socially isolating. At the same time that she is trying to handle these stresses, she may be dealing with many other issues related to the conflict.

There is great variation in the responses of individuals exposed to the stressors associated with war. The psychological and mental health consequences of conflict may be short-lived or lifelong. More commonly, individuals will experience a range of psychological symptoms over time. Somewhat less frequently, providers may encounter clients with psychiatric disorders (Mungherera, M. 2009).

During Activity 1, invite the participants to think broadly about the client's background and perspectives. Providers also need to take into account the stressors and protective factors that each client has been exposed to over time and remember that although clients' experiences may have similarities, each individual is unique and experiences the mix of stressors and protective factors in her own way.

### TRAINING TIP

This exercise is designed to help the participants think about the clients' perspectives in terms of their psychosocial situation. The specific definitions that the participants use to describe their understanding of the terms mental health, stressors, and protective factors are less important than the key concepts. Some of the key concepts (taken from Handout 4-A) include the following:

- There is no universally agreed upon definition of *mental health*, but these are some characteristics shared by people in good mental health:
  - Ability to understand and respond to day-to-day challenges in life
  - Ability to feel and express a range of emotions
  - Ability to maintain good relationships with family and community members

**Stressors** are factors that add to people's stress, and besides the trauma of sexual violence, traumatic fistula clients may be experiencing other stressors common in conflict situations, such as displacement (loss of home, loss of community), the death of their husband, children, or other family members, and a lack of basic needs.

**Protective factors** are qualities in a person or in the surrounding environment that shield a person emotionally and mentally from the full force of a stressful event.

*When finished with this activity, continue to page 70 in this document: Supplement 4B.*

## Supplemental Handout

# Supplemental Handout 4-a

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## Mental Health, Stressors, and Protective Factors

There is no universally agreed upon definition of mental health. But people with good mental health have the following qualities in common:

- Being able to understand and respond to the challenges of day-to-day life
- Being able to feel and to express a range of emotions
- Being able to maintain good relationships among people in families and communities

Many factors, which could be biological or environmental, contribute to having good mental health. People are frequently exposed to positive as well as negative factors in their everyday life. Mental health problems occur when the stress from negative factors—such as pressure from work, illness or death in the family, or lack of income—greatly exceeds normal levels or when the exposure to these negative factors lasts for a long period of time.

During social unrest, people's entire way of life is torn apart. Living conditions may become intolerable, and even the most basic needs may be lacking. These conditions, along with an uncertain future and a constant state of insecurity, put great stress on families and communities. Prolonged stress can break some people down emotionally and mentally, leading to mental health problems. These problems may exhibit themselves physically (fatigue, headache, back pains), emotionally (fear, anxiety, mood changes), or through major changes in behavior (domestic violence, alcohol abuse). Many of these problems can be dealt with. If these problems are not treated early, people can suffer long after the emergency is over.

### Stressors

**Stressors are factors that add to people's stress.** Stressors exist in everyday life (e.g., physical injury, a death in the family, or financial problems). They can cause reactions to problems or difficult situations that are positive or negative. Normal and healthy reactions to stress include a temporary dryness of mouth and feelings of fear or worry. The ability to cope with normal stress depends on various factors, including the nature of the stressor, access to social support, and prior level of functioning. If the stressed person is not cared for early or is ignored, it can develop into a serious mental health disorder. This can bring about the break-up of families and entire communities or even suicide.

Examples of stressors that populations face in conflict situations include:

- Displacement
- Lack of basic needs
- Social disruption
- Exposure to violence

## Protective Factors

Not everyone will respond to a stressful event in the same way. This is as true in extreme situations, such as war, as in everyday life. **Protective factors are qualities in a person, or in the surrounding environment, that shield a person emotionally and mentally from the full force of a stressful event.** The fewer protective factors people have, the more likely they are to develop mental health problems. Knowing what protective factors exist among a displaced population can help agencies select which mental health services should be offered. The first step is to identify those groups or individuals who lack one or more of the following basic protective factors:

1. **Prior Level of Functioning.** People's level of functioning may vary according to their age, sex, personality type, cultural beliefs, etc. Therefore, not everyone comes to a stressful situation with equal abilities to cope mentally and emotionally. People who were having problems functioning before will be especially vulnerable to developing mental health problems during times of widespread violence and social unrest.
2. **Social Support.** The more social support an individual has, the better he or she is able to deal with stress. People separated from their family and community may have a more difficult time coping than people who are surrounded by their family members and community and who have immediate access to support following a stressful event. Not only is being alone stressful, but the events that led to becoming separated from the family and community are often horrific. These people will be at increased risk for developing mental health problems.
3. **Ability to Cope.** The ability to cope is generally greatest when the first stressful event occurs. As more stressful events occur, the likelihood of developing mental health problems increases. An example is a recovering rape victim. Given proper services, a woman has a reasonable chance of recovering her mental and emotional well-being following a rape. However, if a victim is raped a second time, her mental health problems may be far worse than after the first rape.

How long a person is exposed to a stressor also affects his or her ability to cope. For example, the suffering of someone kept in a prisoner of war camp for years may be greater than someone imprisoned for only a few months. In addition, the more intense or traumatic the stressor is, the worse the emotional and mental health problems will be. Some traumatic events may be more deeply felt and may have more long-lasting effects (e.g., torture, watching the slayings of family members, etc.).

4. **Moral Belief Systems.** People have an easier time recovering from traumatic events if they believe they are good, loyal members of the community and if they believe that living with their community is still good for them. But if they have broken moral codes important to the community, they may be tormented by their actions. Also, people may lose faith in the government if officials betray them or act in violent or immoral ways against their own people. Land may no longer be seen as fit for planting if killings took place there.
5. **Return to Normalcy.** It must be remembered that displaced populations are people whose normal life has been disrupted by an emergency situation. A disruption that seems endless creates additional stress, fear, and lower self-esteem. Dependency can develop, which destroys the displaced person and his family's natural way of coping and can worsen symptoms of disability, even in extensive emergency health programs. The more quickly an individual is able to return to a structured daily life, the less likely a mental health problem will develop. For people who were forced to leave a community or who



have lost family members whom they never see again, there may be no return to normal routine. The impact of stressors for these people may stretch indefinitely into the future.

*Note:* This handout was adapted from Chapter 5 (“Emergency Mental Health and Psychosocial Support”) of the following: Johns Hopkins Bloomberg School of Public Health and the International Federation of Red Cross and Red Crescent Societies. 2008. *Public health guide for emergencies*. Baltimore, MD.

Supplemental Resource

## Supplement 4B

### NOTE TO TRAINERS

Supplement 4B provides an overview of what stress and trauma are and how clients may have responded in psychosocial terms to their experience of sexual violence.

## PART B: The Psychosocial Response to Sexual Violence and Traumatic Fistula

*Time: 20 minutes*

### Activity: Large-Group Idea Clustering (20 minutes)

1. Prepare two sheets of flipchart paper, one with the word “fistula” at the top, the second with the word “sexual violence” at the top.
2. Give to each participant two large index cards, two pieces of tape, and a marker.
3. Ask the participants to take one card and write a word to identify one of the feelings that a woman or girl with a fistula might experience. Then ask them to take the other card and write on it one word to describe one of the feelings that a sexual violence survivor might have.
4. When they are finished, invite the participants to tape their cards on the appropriate piece of flipchart paper.
5. Facilitate a large-group discussion about the words written on all of the cards, clustering together the same or similar words under in each area and thinking especially about the overlap in feelings of someone who both has experienced sexual violence and has a fistula.
6. Distribute Supplemental Handout 4-b: Psychosocial Response to Sexual Violence and Traumatic Fistula.

### TRAINING TIP

Women and girls with traumatic fistula might experience related feelings from each of the conditions. Ultimately, a provider's approach to addressing these feelings might be the same regardless of which condition is causing each of the stress symptoms. However, it is important for providers to try to elicit the full range of feelings that each client is experiencing, so as to address her needs as fully as possible.

## TRAINING TIP

Traumatic fistula clients are subject to both stress and trauma related to their medical condition and extreme violence that they have suffered. Session 6 provides more detail about the range of emotions that clients may experience at different points in their experience at the facility. Session 10 provides more detail about the signs of secondary traumatic stress and vicarious traumatization that providers might experience as a result of the work they do.

At this stage in the training, as part of understanding the client's perspective, it is important for the participants to have a basic understanding of what stress and trauma are. They may have questions about these terms, and you may find an appropriate time during this session to share with them the following definitions:

- **Stress** is “the reaction to any real or perceived challenge, demand, threat, or change to which you must adapt. Stress becomes distressing when the demands of the situation exceed your available coping resources.” (Headington Institute. No date. Understanding and coping with traumatic stress. Pasadena, CA. Accessed at: [www.headington-institute.org/Default.aspx?tabid=1384](http://www.headington-institute.org/Default.aspx?tabid=1384))
- **Trauma** is related to stress but is more severe. It can be defined as “...the reaction that occurs when the demands of very stressful events exceed our available coping resources and result in severe distress. This distress has negative consequences for our biological and psychological functioning... Traumatic events are usually either events during which you are seriously physically or emotionally injured, or events that provoke a fear of being killed or seriously injured.” (Headington Institute. No date. Trauma and critical incident care for humanitarian workers. Pasadena, CA. Accessed at: [www.headington-institute.org/Default.aspx?tabid=2072](http://www.headington-institute.org/Default.aspx?tabid=2072))

*When finished with this activity, return to page 92 in the obstetric fistula training curriculum—Part A: Developing Case Studies of Obstetric Fistula Clients.*

Supplemental Handout

## Supplemental Handout 4-b

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### Psychosocial Response to Sexual Violence and Traumatic Fistula

Individuals who have survived sexual assault are at risk of experiencing a number of different emotions and psychological reactions at different times in their recovery. Providers should be aware of the following possible responses in clients who have experienced sexual violence.

#### Fear

As a consequence of the attack, a large number of survivors fear for their lives. Very often, individuals fear being attacked again. As a result of the violence they have suffered, they may also experience more general fears than before this experience, including fear of the dark, fear of being alone, or fear of leaving home on their own. The survivor may fear being pregnant or having HIV or other sexually transmitted infections (STIs) as a result of the rape. The survivor may also fear that she will be unable to have any children as a result of the injury.

#### Anxiety

Sexual violence survivors often suffer from serious anxiety that can result in physical symptoms, such as difficulty breathing, muscle tension, nausea, stomach cramps, or headaches.

#### Anger and Hostility

While anger against the attacker is a normal and justifiable reaction, anger in general can be a difficult emotion to manage in a healthy way. In many cultures, women and children are discouraged from showing their anger. In some cases, the survivor's anger may be inappropriately "misplaced" or "targeted" against others. Health care providers, for example, may experience a hostile reaction from a client without having provoked her in any way.

#### Self-Isolation

Often, sexual violence survivors feel distant and isolated from others and incapable of sharing their experiences with others. They may avoid talking about painful memories and may fear that others will not be able to understand them. They may also fear that they will be rejected by their families and friends. Not talking about the experience, but perhaps reliving it in their own world of nightmares and flash-backs, becomes an impediment to emotional healing and can lead further to self-isolation and withdrawal.

#### Feelings of Powerlessness and Loss of Control

Rape and other forms of sexual violence occur under circumstances where the survivor has lost control of her situation during the attack. Later, this can translate into a generalized feeling of not having control over one's circumstances. For example, if the client voices discomfort or lack of ease with part of the medical exam or other procedures, she may be feeling again a sense of powerlessness and loss of control. It is essential that providers help clients by reinforcing their rights as patients.

## Lethargy

After rape, many survivors go through a period of emotional shut-down and lethargy, which are responses to shock. For individuals in such a situation, this can be a means of establishing control by thinking that if everything is calm around them, nothing bad can happen. This reaction can be misinterpreted by others, but it is not an unusual reaction in people who have been traumatized. It can be thought of as a first line of defense against the horrifying reality that they have experienced.

## Denial and Negation

After the first shock of the attack, even months later, the survivor might deny to others (and even to herself) that she has been attacked. She may try to ignore what has happened to her, as a means of regaining stability.

## Guilt and Self-Blaming

Many individuals who have been raped blame themselves for the attack or think about ways in which they could have avoided having it happen. Some survivors blame themselves for not having done more to fight off the attacker(s). This kind of reaction is related to social biases and victim-blaming that exist in many communities and cultures. The behavior and reactions of friends, family, local authorities, and even health care workers can reinforce the idea that the survivor somehow provoked the attack and is to blame for what happened.

## Shame

Many survivors of sexual violence feel extremely ashamed and embarrassed about what they have experienced. Often, they feel dirty, as if they have been “marked for life.” This kind of reaction, which is very common, is often an impediment to being able to speak about the experience. The level of shame that a survivor experiences may be influenced by the kind of attack and the level of violence that she has endured. For example, the number of attackers involved, whether weapons were used, etc., can affect the client's perception of her situation and her feelings of shame.<sup>1</sup>

## Loss of Confidence

The experience of rape brings with it a hard reality: that the survivor was in a situation where she was unable to protect herself, even if she had tried with every bit of force. In the moment of the attack, she lost control. The attack was not only a humiliating invasion of her physical being, but it was also an invasion of her intellectual, social, and emotional being. For the survivor, this experience brings up many questions about vulnerability in general, which can greatly damage self-esteem and confidence.

## Mood Swings

After the attack, survivors' emotions can change quickly, passing from extreme emotional pain and sadness to complete lack of emotion. They may at one time feel nothing or feel depressed, while in the next moment they may become agitated, disoriented, or very angry. Feeling this way, at the mercy of one's shifting emotions, can give an impression that the survivor is psychologically unstable—both to the survivor herself and to others.

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<sup>1</sup> This is based on additional input on clients' experiences of shame provided by participants at the Traumatic Fistula Counseling Workshop, held in March 2009 in Kampala, Uganda.

## **Depression**

A great number of sexual violence survivors go through periods of depression. Symptoms can include anxiety, self-hatred, lethargy, weight gain, loss of appetite, sleeping difficulties, and other physical manifestations of stress.

## **Flashbacks and Nightmares**

Flashbacks are frequent memories of the attack that can come suddenly and without warning. Sometimes the flashbacks are so strong that the survivor has the impression that she is reliving the experience. Individuals who have survived a sexual attack may spend many nights having nightmares or not sleeping at all. Nightmares cause the survivor to relive the attack and point to certain issues around the attack that have not been resolved.

*Source: United Nations Population Fund (UNFPA). 2005. Module de formation des prestataires: volet psychosocial. For l'initiative conjointe de prevention des violences sexuelles et de reponses aux droits et besoins des victimes/survivant(e)s. Kinshasa, DRC: UNFPA.*

### Supplemental Resource

## Additional Training Considerations for Developing Case Studies

When the training participants begin the process of developing case studies, the trainers should ensure that they consider the full range of characteristics, including those related to traumatic fistula. For instance, when discussing the differences between characteristics, situations, and emotional and physical conditions, the trainers should be sure to include under “situations” one specific to traumatic fistula (such as “having experienced sexual violence in public, such that everyone in the community knows she has been raped, rather than very few people knowing she has been raped”). Likewise, “emotional and physical conditions” might include having suffered other physical injuries due to rape rather than having no other physical injuries, or being accompanied to the facility by family members instead of having been rejected by family members and thus traveling to the facility alone.

When developing the initial client profiles (which focus only on the client's demographic and social characteristics), be sure to include at least one with characteristics that will be relevant to traumatic fistula. Some examples include the following:

- Yvette: age 24; married; two children; nonliterate and has never been to school; husband lets her stay in the house but has taken a second wife; has no income and depends on husband for livelihood (see sample case study on page 76)
- Josephine: age 8; both parents killed in conflict; has one brother, age 10; lives with an aunt and the aunt's husband and family; started primary education before her parents were killed, but is no longer in school
- Mariam: age 50; widowed; three daughters, one son (the son and one of the daughters have been killed in the conflict); living with a daughter, age 34, and daughter's family; educated up to first-year secondary school; has a small tailoring business in town and helps her daughter in family agriculture.

The trainers should emphasize that developing a case study is a little like writing a story: You think about what you know about the main character, then you try to imagine what happened to the woman or girl that resulted in her being in this situation and having these emotional and physical conditions. In describing how a character came to have a traumatic fistula, ask the participants to also provide detail on the assailant(s) in the sexual violence incident that led to the injury. If it was caused by soldiers, for example, they should provide details on whether high-ranking officers were involved or others. Also, they should describe the number of assailants and the types of weapons used, if any. These details can all influence the level of injury and the level of fear that a client might have in discussing her situation with providers.

## **SAMPLE CASE STUDY FOR “YVETTE”**

### **Yvette, Age 24, Democratic Republic of Congo**

At the age of 18, Yvette married a man of 24 who lived in a remote rural area. She became pregnant within the first year of marriage and gave birth to a healthy baby boy. Two years later, she had another child, this time a girl. When she was 23, war came to the small village where Yvette and her young family were living. One day, after collecting firewood, she was violently attacked by a group of six men who looked like rebels. They were all young, except for one who was older and looked like a rebel officer. Some of the men used branches from the wood pile she had collected. She managed to get home and tried to hide what had happened, but she suffered from terrible pain and soon noticed that she was constantly leaking urine. Her husband confronted her, and when she told him what had happened, he said she had to leave the house. Begging, she convinced him to let her stay in the family compound, but he soon took a second wife and would have nothing more to do with her. She was allowed to stay in her own hut within the compound, but she and her children were completely dependent on her husband and the second wife for all of their needs.

*When finished with this activity, return to page 93 in the obstetric fistula training curriculum—Part A: Activity 2.*



**Supplemental Resource****Additional Information Regarding Confidentiality, Privacy, and Dignity**

During Part B: Confidentiality, Privacy, and Dignity, the trainers should consider incorporating a video training tool on clinical counseling for survivors of sexual violence. Developed by the International Rescue Committee in 2007, *Clinical Care for Sexual Assault Survivors: A Multimedia Training Tool* provides a good overview on confidentiality, privacy, and dignity, as well as containing a section that addresses the issue of informed consent.

For more information about this video, go to: [www.theirc.org/resources/2007/clinical-care-for-sexual-assault-survivors-dvd-brochure.pdf](http://www.theirc.org/resources/2007/clinical-care-for-sexual-assault-survivors-dvd-brochure.pdf).

*When finished with this activity, go to page 98 in the obstetric fistula training curriculum—Part C: Addressing the Client's Feelings.*



## Session 5

# Interpersonal Communication

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Session 5 of *Counseling the Obstetric Fistula Client* focuses on communication with fistula clients, particularly the benefits of two-way communication, the need to use simple language, and the advantages of using the REDI counseling framework (Rapport Building, Exploration, Decision Making, and Implementing the Decision). All of this continues to be important for dealing with traumatic fistula clients as well. However, counseling support to clients can be enhanced through techniques or key messages that may be especially helpful for individuals who have survived trauma. Therefore, this supplement provides some additional material on effective listening, on approaches to verbal and nonverbal communication that clients may find supportive or unsupportive, and on the use of paraphrasing, praise, encouragement, and empathy within the context of counseling.

To integrate the traumatic fistula information into this session, refer to the following elements in this supplement (as directed in the blue box instructions in the obstetric fistula counseling curriculum):

- Alternative Session 5 Overview: Session Objectives, Points to Remember, Training Methods, Materials, and Advance Preparation (pages 80–85)
- Supplemental Resource: Part B Additional Discussion Point (page 86)
- Supplemental Handout 5-a: Nonverbal Communication (pages 87 and 88)
- Supplemental Resource: Part C Additional Discussion Point (page 89)
- Supplemental Resource: Part D, Activity 1—Alternative Sample Completed Flipchart (page 90)
- Supplemental Resource: Part D, Activity 3—Alternative Sample Completed Flipchart (page 91)
- Supplemental Resource: Supplement 5A: Positive Feedback through Paraphrasing, Praise, Encouragement, and Empathy (pages 92 and 93)
- Supplemental Handout 5-b: Paraphrasing, Praise, Encouragement, and Empathy (pages 94 to 96)
- Supplemental Resource: Part F Additional Discussion Point (page 97)

## Alternative Session 5 Overview

# Session 5 Overview

## Session Objectives

As a result of this session, the participants will be able to:

- Explain the differences between one-way and two-way communication
- Discuss the importance of nonverbal communication when dealing with fistula clients
- 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 fistula
- Give examples of using paraphrasing, praise, encouragement, and empathy to provide positive feedback when counseling fistula clients
- 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.
- ✓ Nonverbal channels of communication may convey as much about a provider's attitudes toward clients as his or her words.
- ✓ 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.
- ✓ *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.

(continued)

## POINTS TO REMEMBER (continued)

- ✓ 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.
- ✓ One psychosocial consequence of sexual violence and traumatic fistula that women and girl clients face is an erosion of self-confidence and self-esteem; an effective counselor can help the client to start feeling better about herself, using techniques such as paraphrasing, praise, encouragement, and empathy.
- ✓ The elements of the REDI counseling framework are: Rapport-Building, Exploration, Decision Making, and Implementing the Decision.
- ✓ Counselors can use the same REDI framework when discussing options and decisions with the parent or guardian of young clients.
- ✓ 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
- Supplemental Handout 5-a: Nonverbal 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
- Supplemental Handout 5-b: Paraphrasing, Praise, Encouragement, and Empathy
- 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 Supplemental 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 Supplemental Handouts 5-a and 5-b, 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:

<i>Closed-Ended/Information Questions and Open-Ended/Feeling Questions</i>		
<b>Questions</b>	<b>Structure (Closed- or Open-Ended)</b>	<b>Content (Information or Feeling)</b>

6. Prepare a flipchart for each of the steps of the REDI Counseling Framework, as in the examples on pages 83 and 84, for Part F, Activity 2:

*Rapport Building*

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

*Exploration*

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

*Decision Making*

<b>Decision Making</b>	<b>Already Doing</b>	<b>Need Training</b>	<b>Challenges Anticipated</b>
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*

<b>Implementing the Decision</b>	<b>Already Doing</b>	<b>Need Training</b>	<b>Challenges Anticipated</b>
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 Time (total): 5 hours, 30 minutes*

*Go to page 113 in the obstetric fistula training curriculum—Session 5 Training Steps.*

### Supplemental Resource

## Part B: Verbal and Nonverbal Communications Activity: Additional Discussion Point

Nonverbal channels of communication (such as the provider's positioning with respect to the client, facial expressions, extent of eye contact, and physical gestures) may say as much about a provider's attitudes toward clients (particularly those who have been raped or sexually abused) as his or her words do. Therefore, providers need to be particularly aware of their nonverbal communication.

Distribute and briefly discuss Supplemental Handout 5-a: Nonverbal Communication before concluding this activity.

*Go to page 115 in the obstetric fistula training curriculum—Part B Activity, Step 9.*

## Supplemental Handout

# Supplemental Handout 5-a

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## Nonverbal Communication

In daily interactions with other people, we all use verbal and nonverbal communication to express what we think and feel. Much of both verbal and nonverbal communication is done without even being aware of it. The way we say something and the words we choose can “speak volumes” about what we really think. At the same time, a major part of communication does not involve any words at all. There are both positive and negative forms of nonverbal communication. Some examples of each follow:

### Positive nonverbal cues

- Leaning toward a client
- Smiling
- Avoiding nervous mannerisms
- Presenting interested facial expressions
- Maintaining eye contact
- Making encouraging gestures such as nodding one's head

### Negative nonverbal cues

- Reading from a chart
- Glancing at one's watch
- Yawning
- Looking out the window
- Fidgeting
- Frowning
- Not maintaining eye contact

*(Adapted from: EngenderHealth Society, 2006. Adherence to treatment for HIV: A training curriculum for counselors. Participant manual. New Delhi, pp. 75–76)*

## **Cultural Differences, Eye Contact, Personal Space, and Personal Contact**

As health care providers and counselors, you may need to use a variety of approaches with your clients in terms of eye contact, personal space, and personal contact, depending both on culture and on personal preferences. You must be observant and open to adapting your own behavior to ensure that the client is as comfortable as possible and to facilitate the ease with which she may communicate with you about her needs.

Typically, maintaining eye contact is an important nonverbal cue that can let the client know that you are focused on understanding her situation and are interested in hearing her story and helping her to find solutions.

However, it is important to keep in mind that in some cultures, **maintaining eye contact is inappropriate**. It is even possible that the client will prefer talking with you with her back turned to you, either because of culture or feelings of shame and/or guilt. While you should eventually be able to help with emotional issues, it is important to understand the basics of the interpersonal communication habits of people from other cultures whom you frequently encounter in your services.

People may also have very different needs and levels of comfort regarding personal space. Some clients who have experienced sexual violence may feel a need to maintain personal space, and it may feel most comfortable for that client to share information if there is a physical separation, such as a desk, between herself and the care provider while discussing her situation. For others, it may be more appropriate to take a chair and sit next to or directly opposite her, to establish an easy communication that becomes more familiar and less formal. Again, culture and personal preferences will both play a role, and it is important to be as observant as possible with each client.

Similarly, the level of personal contact that is appropriate depends highly on both culture and personal preference. In many cultures, gently placing a hand on the forearm or shoulder of a client who is distressed may signal empathy and support, but in other cultures it may be entirely inappropriate. Additionally, some clients who have experienced sexual violence may be especially sensitive to personal contact and may not wish to be touched, even to shake hands. If a client rejects physical contact that is typical for her culture, the provider should not take offense. Rather, it is crucial to try to understand the client's experience and needs and to take her physical cues into account during further interpersonal communication.

## Supplemental Resource

**Part C: Active/Effective Listening: Additional Discussion Point**

It is important for the trainers to understand that counselors and medical staff who work with clients suffering from sexual violence and traumatic fistula often work long hours under difficult conditions. They hear terrible stories of human suffering, day in and day out. Eventually, they may start to “zone out,” thinking that they know what they are about to hear from clients, and they may routinely take the same approach with each client. While understandable, this can lead to a breakdown in communication between the client and provider, and it ultimately puts the quality of the service and the client's outcome at risk.

This applies to client-provider interactions for any health concern, but it is especially relevant for sexual violence and traumatic fistula, due to the sensitive nature of the client's health concerns. As highlighted in *Adherence to Treatment for HIV: A Training Curriculum for Counselors* (EngenderHealth Society, 2006):

When a counselor does not listen well, it is easy for a client to assume that his or her situation is not important to the counselor, or that he or she as an individual is not important to the counselor. Thus, it is hard to develop the trust necessary for good counseling if the counselor is not listening effectively. Effective listening is also a key communication skill for counseling. It is important for most efficiently determining:

- What the client needs
- What the client's real concerns are
- What the client already knows about his or her situation
- What the client believes about what he/she can do
- What the client's expectations are

Barriers to effective listening can include the following: the physical environment; body language; delivery/ tone of voice; language; and appearance (FHI, RHRC Consortium, and IRC, no date).

*Return to page 117 in the obstetric fistula training curriculum—Part D: Asking Open-Ended Questions.*

Supplemental Resource

**Part D, Activity 1—Alternative Sample Completed Flipchart**

\*\*\* SAMPLE – DO NOT COPY CONTENT \*\*\*

*Closed-Ended/Information Questions and  
Open-Ended/Feeling Questions*

Questions	Structure (Closed- or Open-Ended)	Content (Information or Feeling)
1. How long ago were you raped?		
2. How did the attacker(s) rape you?		
3. Did the men who assaulted you use any weapons?		
4. What medical care did you get after the rape?		
5. Have you been tested for HIV or other sexually transmitted infections?		
6. How long have you been in this condition?		
7. How have you felt about yourself since the day you were attacked?		

*Return to page 118 in the obstetric fistula training curriculum—Part D: Activity 2.*

## Supplemental Resource

## Part D, Activity 3—Alternative Completed Flipchart

\*\*\* SAMPLE Completed Flipchart for Activity 3—DO NOT COPY CONTENT \*\*\*

<i>Closed-Ended/Information Questions and Open-Ended/Feeling Questions</i>		
<b>Questions</b>	<b>Structure (Closed- or Open-Ended)</b>	<b>Content (Information or Feeling)</b>
1. How long ago were you raped?	<b>c</b>	<b>I</b>
2. How did the attacker(s) rape you?	<b>o</b>	<b>I</b>
3. Did the men who assaulted you use any weapons?	<b>c</b>	<b>I</b>
4. What medical care did you get after the rape?	<b>o</b>	<b>I</b>
5. Have you been tested for HIV or other sexually transmitted infections?	<b>c</b>	<b>I</b>
6. How long have you been in this condition?	<b>c</b>	<b>I</b>
7. How have you felt about yourself since the day you were attacked?	<b>o</b>	<b>F</b>

Go to page 120 in the obstetric fistula training curriculum—Part E: Using Simple Language and Visual Aids.

Supplemental Resource

# Supplement 5A

## Positive Reinforcement through Paraphrasing, Praise, Encouragement, and Empathy

*Time: 55 minutes*

### Activity 1: Presentation/Discussion (10 minutes)

1. Present an overview of the terms paraphrasing, praise, encouragement, and empathy, as applied to counseling for traumatic fistula.
2. Provide each participant with a copy of Supplemental Handout 5-b: Paraphrasing, Praise, Encouragement, and Empathy.
3. Guide a brief discussion of these terms by inviting the participants to share their understanding and use in their counseling work.

#### TRAINING TIP

At this point in the Session 5 training, the participants have been exposed to five different components of interpersonal communication: (1) two-way communication; (2) verbal and nonverbal communication; (3) active/effective listening; (4) open- and closed-ended questions; and (5) positive feedback through paraphrasing, praise, encouragement and empathy. Over time, effective counselors become skilled in applying each of these at the right time in counseling with every patient. However, missing out on only one area can sometimes reduce the quality of the counseling experience. It is important that counselors try to become skilled in all of the areas, as Activity 2 below helps to demonstrate.



## Activity 2: Role Play (45 minutes)

1. Divide the participants into the same groups that developed the case study clients in Session 4.
2. When the participants are in their groups, explain that they will be doing a role play that involves a traumatic fistula client (using one of the characters developed in earlier sessions) and at least one provider. The groups may wish to create additional characters, such as family members, other providers, etc., but at a minimum there must be the client and the provider.
3. The client will tell her story to the provider, and the provider will counsel her as needed, using all but one of the key communication skills discussed so far in Session 5 (i.e., two-way communication; verbal and nonverbal communication; active/effective listening; open- and closed-ended questions; and positive feedback through paraphrasing, praise, encouragement, and empathy).
4. Before the groups start to develop their role plays, go to each group and tell them which of the five communication skills they should “leave out.” It is important that the participants in each group know only the skills area that they are leaving out, but not the skills areas to be left out by each of the other groups.
5. Have each group should present their role play for five minutes. Then ask the participants not in the presenting group to discuss which skills area they think was missing from each role play.
6. After all of the groups have finished, facilitate a discussion about the experiences of the characters in each of the role play. Ask the participants which of the skills areas they thought were missing from each of the other role plays, and compare their responses to what had been assigned to each group.

*Go to page 122 in the obstetric fistula training curriculum—Part F: Counseling Framework: REDI.*

## Supplemental Handout

# Supplemental Handout 5-b

## Paraphrasing, Praise, Encouragement, and Empathy

One of the possible—indeed, likely—psychosocial consequences of sexual violence and traumatic fistula that women and girl clients face is an erosion of self-confidence and self-esteem. In addition to listening to the client, offering information, and providing links to additional services, an effective counselor can help the client to start feeling better about herself, even after their first meeting.

Paraphrasing, praise, encouragement, and empathy are important parts of the communication process between the counselor and the client. Definitions of each of these terms are provided below.

**Paraphrasing** means “restating the client’s message simply and in your own words. The purposes of paraphrasing are to (1) make sure you have understood the client correctly; (2) let the client know that you are trying to understand her basic message; and (3) summarize or clarify what the client is trying to say” (adapted from: EngenderHealth, 2003, p. 82).

**Praise** is “the expression of approval or admiration. In the health care setting, to give praise is to reinforce positive behavior—that is, identify and support the health-seeking behavior of clients” (EngenderHealth & ICW, 2006, Participant Handout 4.1: Communication Skills of an Effective Counselor, p. 106). Examples include:

- Showing respect for the client’s concern for her own health
- Acknowledging the difficulties she may have overcome to be at the facility

**Encouragement** is “giving courage, confidence, and hope. In the health care setting, to give encouragement means letting clients know that you believe they can overcome their problems and helping them find ways to do so” (EngenderHealth & ICW, 2006, Participant Handout 4.1: Communication Skills of an Effective Counselor, p. 106). Examples include:

- Pointing out possibilities and reasons for hope
- Focusing on the positive things that a client has done to help herself and urging her to continue that action and/or finding new ways to tap into her own resilience

**Empathy** is the ability to put yourself in the client's position and understand her point of view as if it were your own. It is being able to "put yourself in the client's shoes." It is different from "sympathy," which is feeling sorry for another person (EngenderHealth Society, 2006).

**Examples of ways to apply paraphrasing, praise, encouragement, and empathy with sexual violence and traumatic fistula clients include the following:**

### **Paraphrasing**

Health care providers and counselors can show a client that they understand what she is trying to tell her by paraphrasing. For example, if a client says something like:

- "I don't know what to do. Every day, I feel that people in my village are looking at me strangely because they know what happened to me. My husband will have nothing to do with me. He has threatened to throw me out of the house—what will happen then—what will happen to my children? How will I be able to feed them? I don't know where I will get any money if my husband cuts me off. My parents were killed in the war, and I have nowhere to turn. Everyone is scattered. Everything is upside down. I must find a way to make sure the children will be okay."

The provider can help the client to focus and to know that she is being heard, by paraphrasing:

- "It sounds like you are in an extremely difficult and frightening situation, especially when it comes to the welfare of your children. You will find a way to make sure the children's needs are met."

### **Praise**

To show respect for the client's concern for their own health, the provider might say:

- "You are very smart to come to get medical care so soon after you were attacked. We will be able to offer you a variety of services that might not have been an option if you had waited longer. It's great that you have come when you have, and we will do everything we can to help you."

To acknowledge the difficulties that she may have overcome to be at the facility, the provider could observe to the client:

- "You have come a great distance to find help and even risked coming through insecure areas. That is impressive—you are very brave!"

### **Encouragement**

To encourage a client to build on her own strengths and resilience and to continue taking positive actions toward recovery, the provider might remind her:

- "You can be proud that you have been able to survive the emotional and physical difficulties that you have had to face. The future should soon be easier for you in many ways, but you will always be able to rely on the strength you have to overcome challenges."
- "It is wonderful that you have joined the sexual survivors' organization. They have many programs that can help, and you have a lot to offer the other members."

## Empathy

When listening to the story of a client, the provider can empathize and show that he or she can in some way identify with the client's experiences and feelings, by saying something like the following:

- “Your experiences have been extremely difficult and would be a challenge to any woman. You do not need to feel ashamed about this experience. We have all suffered terribly in this war in many ways and have faced so many problems. We are here to help you get through this together.”

## References

EngenderHealth. 2003. *Comprehensive counseling for reproductive health. An integrated approach*. Trainer's manual. New York.

EngenderHealth and International Community of Women Living with AIDS (ICW). 2006. *Sexual and reproductive health for HIV-positive women and adolescent girls: Manual for trainers and programme managers*. New York and London.

EngenderHealth Society. 2006. *Adherence to treatment for HIV: A training curriculum for counselors. Participant manual*. New Delhi.

## Supplemental Resource

**Part F: Counseling Framework: REDI—Additional Discussion Point**

In the presentation of the REDI counseling framework, the trainers should explain to the participants that the REDI framework is a counseling tool designed to help clients think about their situation and consider any decisions about their medical care that they need to make, as well as to guide them in both making and implementing their decisions. However, some traumatic fistula clients are girls and young adolescents, and they may not be in a position to fully understand their medical condition and/or the decisions they may need to make. In such cases, a parent or guardian may be making a decision on behalf of the child. Counselors can use the same REDI framework when discussing options and decisions with the parent or guardian of young clients.

*Return to page 123 in the obstetric fistula training curriculum—Part F: Activity 2.*



## Session 6

# Counseling for the Traumatic Fistula Client

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Session 6 of *Counseling the Obstetric Fistula Client* provides an overview of counseling and offers a detailed outline of the process for counseling fistula clients. However, counseling may need to be especially intensive when clients have experienced severely traumatizing events and may lead to difficult moments in which counselors ask themselves why they have chosen to enter this often challenging profession.

To integrate the traumatic fistula information into this session, refer to the following elements in this supplement (as directed in the blue box instructions in the obstetric fistula training curriculum):

- Alternative Session 6 Overview: Session Objectives, Points to Remember, Training Methods, Materials, and Advance Preparation (pages 100–103)
- Supplemental Resource: Supplement 6A: Dealing with the Challenges of Counseling Traumatic Fistula Clients (pages 104–107)
- Supplemental Handout 6-a: What Is Counseling? (pages 108–111)
- Supplemental Handout 6-b: Qualities of an Effective Counselor (pages 112 and 113)
- Supplemental Resource: Supplement 6B: Counseling Traumatic Fistula Clients (Psychosocial Issues) (pages 114–117)
- Supplemental Handout 6-c: Counseling Strategies for Addressing Emotional Reactions to Sexual Violence (pages 118–120)
- Supplemental Resource: Part A Additional Discussion Points (page 121)
- Supplemental Handout 6-d: Preparing the Traumatic Fistula Client for the Initial Physical Examination (pages 122 and 123)
- Alternative Participant Handout 6-e: Overview of Clinical Intake (pages 124–134)
- Alternative Participant Handout 6-i: Overview of Discharge and Follow-Up (pages 135–137)
- Supplemental Resource: Part B, Activity 3 Training Tip (page 138)
- Supplemental Resource: Part C, Activity 4 Additional Discussion Points (page 139)

## Alternative Session 6 Overview

# Session 6 Overview

## Session Objectives

As a result of this session, the participants will be able to:

- *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 psychosocial issues to be addressing when counseling traumatic fistula clients
  - The unique counseling needs of clients with special needs (i.e., clients who are very young, older, HIV-positive, physically disabled, or mentally or developmentally disabled)
- *Examine:*
  - Counseling in the context of existing services for women with fistula
  - The challenges and benefits of counseling traumatic fistula clients
- *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 for 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
- ✓ 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
- ✓ Counseling the survivors of sexual violence:
  - Includes a discussion of relevant feelings and concerns to help clients focus on managing emotions associated with their situation
  - Enables clients to apply information to their particular circumstances
- ✓ 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 titled “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.
- Supplemental Handout 6-a: What Is Counseling?
- Supplemental Handout 6-b: Qualities of an Effective Counselor
- Supplemental Handout 6-c: Counseling Strategies to Address Emotional Reactions to Sexual Violence
- Participant Handout 6-A: Stages of Service Delivery
- Participant Handout 6-B: Counseling the Obstetric Fistula Client
- Supplemental Handout 6-d: Preparing the Traumatic Fistula Client for the Initial Physical Examination
- 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
- Alternative 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)
- Alternative 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 Time (total): 6 hours, 25 minutes, to 7 hours, 50 minutes*

*Go to page 141 in the obstetric fistula training curriculum—Session 6 Training Steps.*

Supplemental Resource

# Supplement 6A

## NOTE TO TRAINERS

Supplement 6A is designed to help the participants reflect on what they gain from their counseling experiences, articulate for themselves their own strengths and weaknesses, and remind themselves what it is like to discuss personal feelings and thoughts with someone whom they do not necessarily know very well, or whom they may already know well. (Both situations can be uncomfortable.) The goal is to lead the participants to focus on techniques for helping clients feel confident in them as counselors and comfortable about sharing the personal and often painful details of their experiences.

## PART A: Dealing with the Challenges of Counseling Traumatic Fistula Clients

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*Time: 55 minutes*

### Activity 1: Warm-Up (15 minutes)

1. Divide the participants into smaller groups of 4–5 participants per group.
2. Provide a sheet of flipchart paper and a marker to each group.
3. Ask each participant to think of a time in their life when they looked to someone for counseling on an issue that was important to them and to write on a piece of notebook paper a brief definition of what “counseling” meant to them in this situation.
4. Ask the participants in each group to share what they have written with the other members of their group and briefly discuss.
5. Using the flipchart paper, ask each group to write a definition of counseling that is simple but includes as many of the key concepts from everyone’s definitions as possible.
6. Ask one member from each group to present the group’s definition to the rest of the participants.
7. Facilitate a discussion about the similarities, differences, and key points across the definitions.
8. Provide each participant a copy of Supplemental Handout 6-a: What Is Counseling?
9. Review the key points from this handout, observing important similarities and/or differences compared with the definitions created by the small groups.

**TRAINING TIP**

At some time, almost everyone has either been counseled or provided counseling, or both, formally or informally. Everyone has an idea of what it is in practice, yet it can be challenging to define. The participants may have different understandings of the term counseling according to their own experiences. During this exercise, focus on the similarities across participants' understanding of counseling and refer frequently to the following key points to help guide the discussion:

- Counseling the survivors of sexual violence includes a discussion of feelings and concerns because they are relevant to the clients' choices and emotional recovery.
- Counseling focuses on helping individuals make choices and manage emotions associated with their situation.
- Counseling goes beyond just giving facts by enabling clients to apply information to their particular circumstances and to make informed choices.

Recall also that a definition of counseling was provided in Session 3 (Handout 3-A) as "The process of helping a client confirm or make informed and voluntary decisions about her individual care."

**Activity 2: Paired Discussion and Group Discussion (20 minutes)**

1. Ask the participants to individually think about the following questions and write their personal answers on a piece of notebook paper.

*Questions:*

- Why do I want to do counseling?
  - What do I gain from helping others?
  - How might my personal interests or needs interfere in my capacity to help others?
  - What qualities do I have that may be useful in helping others?
  - What weaknesses do I have that could diminish my capacity to help others?
2. Ask the participants to pair up with someone who is not sitting directly next to them. All of the participants should be in pairs.
  3. Tell the participants that ample time will now be given to each of them to discuss their responses to these questions.
  4. Ask the participants to think about whether they will share with the other person all of their answers to the questions above, or if they only want to talk about some of the questions, depending on how comfortable they feel in discussing each of the points.

5. Ask the participants to discuss (some or all of) the questions with the other person in their pair for the next 10 minutes.
6. After 10 minutes, reassemble the participants into one large group and ask those who chose to discuss all of their responses to raise their hands. Count how many people did so, and then ask those who did not want to discuss all of the questions to raise their hands.
7. Facilitate a brief discussion about the following points:
  - The importance of being able to articulate the reasons for doing this kind of work and the possible difficulties in identifying these reasons for oneself
  - The limits we each have in wanting to disclose personal information about ourselves, even on topics that appear very “normal”
  - The key points that arose from the discussions: What did participants learn about themselves? Why do they want to do this kind of work? What are the personal factors that can help and hinder them in being effective counselors?

*Adapted from:* UNFPA, 2005.

### TRAINING TIP

As will be further addressed in Session 10, counseling is *intensive* work, especially when clients have experienced severely traumatizing events. There may be difficult times when counselors ask themselves why they have chosen to go into this often challenging profession. This exercise can help counselors to reflect on what they gain from their experiences, which can be a helpful reminder in difficult times. As well, it can help providers to articulate for themselves their own strengths and weaknesses. Last but not least, this exercise is designed to remind counselors what it is like to discuss personal feelings and thoughts with someone whom they do not necessarily know very well—or whom they may already know well. (Both situations can be uncomfortable.) Through the work on communications skills in Session 5 and the exercises in Part B of Session 6, the participants will focus on techniques to help clients feel confident in them as counselors and comfortable about sharing personal and often painful details of their experiences.

### Activity 3: Memory Game (20 minutes)

1. Ask the participants to form a large circle.
2. Ask everyone to write down on a piece of paper five qualities of an effective counselor or other service provider whom they have been helped by in the past or whom they have come to know about through their work.

3. Ask for a volunteer to share with the group one of the qualities they have written down, saying, “One quality of an effective counselor is...”
4. Ask the person sitting to the right (or left) of the first participant to continue by saying, “Two qualities of an effective counselor are...” (the quality identified by the first participant and then the quality that the second participant thought of).
5. Continue this with the person sitting next to the second participant, etc., until someone forgets the order of qualities mentioned.
6. Start over with the person who has forgotten the order, and have that person say: “One quality of an effective counselor is...” (Note: The participant should identify a new quality that no one else in the group has mentioned yet; no repeat qualities are allowed, but participants can look at their list of five qualities that they have written down at the beginning of the exercise.)
7. Continue with the next participant and so on, until each participant has had a chance to identify one new quality that they think a counselor should have.
8. Distribute Supplemental Handout 6-b: Qualities of an Effective Counselor.

Source: Introduction to engagement skills techniques; in: FHI, FHI, RHRC Consortium, and IRC, no date.

### TRAINING TIP

As the participants recall each of the characteristics of an effective listener, write down each one on notebook paper so that you can summarize each of the points and compare them with Handout 6-B together as a group.

*When finished with this activity, continue to page 114 in this document: Supplement 6B.*

Supplemental Handout

# Supplemental Handout 6-a

## What Is Counseling?

Counseling is a process to help an individual identify problems, examine potential solutions, and help make the decisions that are best for him or her (EngenderHealth Society, 2006, Section 3: The Elements of Counseling, p. 75). Ultimately, it is a process of helping clients confirm or make informed and voluntary decisions about their individual care.

### Characteristics of Counseling

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 traumatic fistula clients.

## **Special Counseling Needs of the Traumatic Fistula Client**

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

1. Understand what caused her condition (to dispel any myths or misperceptions), so that she can participate in its management
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 risks of unwanted pregnancy and the possible transmission of HIV and other sexually transmitted infections (STIs), and related prevention possibilities (if the client has come to the clinic within the applicable time period)
4. Understand the scope of treatment and success rates, risks, and benefits
5. Know about the availability of fistula repair
6. Understand the possible outcomes of treatment
7. Understand the possible physical effects of trauma and stress due to sexual violence
8. Understand her own role in managing her condition
9. Have clear preoperative and postoperative instructions
10. Understand the importance of her own personal hygiene
11. Become involved in client-support groups within the facility
12. Be exposed to fistula success stories
13. Understand possible preoperative and postoperative complications
14. Understand the issues in reproductive health and sexual rights (including family planning) that might affect her
15. Understand her fertility potential after treatment
16. Understand options if repair either is not possible or has been unsuccessful
17. Understand how to care for herself after surgery, including how to maintain good nutrition, how to cook her food, and how to ensure good personal hygiene
18. Understand the need to abstain from penetrative vaginal intercourse and to avoid inserting any object into her vagina for at least three months after the surgical fistula repair

19. Understand how to care for herself and where to go for care during any subsequent pregnancy or childbirth (e.g., the need for her next delivery to be in a facility)
20. Use her own knowledge and experience in bringing other fistula clients and sexual violence survivors to facilities
21. Contact community organizations that work with women with fistulas and/or sexual violence survivors, and tap into income-generating activities and educational opportunities

**Emotional Support:** Counselors will need to ensure that a traumatic fistula client:

1. Feels welcome and safe 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. Understands that she is not at fault for her condition
11. Has coping skills to manage depression or other emotional consequences of traumatic fistula

**Clinical Management:** Health systems should ensure that traumatic fistula clients have:

1. Easy access to health services
2. Access to quality treatment/surgical repair for traumatic 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 traumatic 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; and EngenderHealth Society. 2006. Adherence to treatment for HIV: A training curriculum for counselors. Participant manual. New Delhi.*

## Supplemental Handout

# Supplemental Handout 6-b

## Qualities of an Effective Counselor

Effective counseling is a crucial component of a successful treatment experience for clients with traumatic fistula. In the hospital or clinic setting, counseling might be provided by a wide range of individuals, including psychology staff, social workers, nurses, and doctors. Religious leaders, professionals in legal and protection services, and community program staff are also called upon to counsel women and girls who have suffered sexual violence. Regardless of job description, everyone involved in addressing the needs of traumatic fistula patients needs to be an effective counselor in order to help each client understand what is happening to them, what their choices are, and how to prepare for the next steps.

### What Is an Effective Counselor?

In supporting women and children who are suffering from traumatic fistula, an effective counselor has many of the same qualities as effective counselors in sexual and gender-based violence generally. An effective counselor is **“...a trusted confidante who listens, reassures, and accepts the survivor; guides her in exploring options and deciding what, if any, action she wishes to take; and advocates for her if she needs and requests such assistance”** (Vann, 2002).

### Characteristics of an Effective Counselor:

- Is genuine/sincere, empathetic, compassionate, and patient
- Creates an atmosphere of privacy, respect, and trust
- Is nonjudgmental: Offers choices and does not judge the person's decisions
- Is a good communicator: Engages in a dialogue or open discussion
- Is reliable (i.e., provides accurate information)
- Is comfortable discussing sexual violence, traumatic fistula, and related issues, including sexual and reproductive health in general and specific health concerns such as undesired pregnancy and HIV
- Helps the client to express her needs and concerns
- Talks in moderate pace and appropriate volume
- Presents messages in clear and simple language (language clients can understand)
- Asks questions of the listener to make sure that he/she understands
- Helps the client identify obstacles and works to remove them

*Adapted from:* EngenderHealth Society, 2006.

## Characteristics of a Poor Counselor:

- Interrupts the conversation (for example, to meet with other people or to answer the telephone)
- Provides counseling in the presence of other people (without consent)
- Makes decisions for clients
- Breaks confidentiality
- Has poor nonverbal communication skills (looks away, frowns, etc.)
- Lacks knowledge about and/or is uncomfortable discussing traumatic fistula, sexual violence, undesired pregnancy, HIV and AIDS, and other sexual and reproductive health issues
- Is difficult to understand
- Does not ask questions, only tells the person what to do
- Is impatient
- Is rude

*Adapted from:* EngenderHealth Society, 2006.

## References

- EngenderHealth Society. 2006. Section 3: The Elements of Counseling. In *Adherence to treatment for HIV : A training curriculum for counselors. Participant manual*. New Delhi, pp. 75–87.
- Vann, B. 2002. Defining counseling, in *Gender-based violence: Emerging issues in programs serving displaced populations*. Arlington, VA: JSI Research and Training Institute (on behalf of the Reproductive Health for Refugees Consortium), p. 69.

Supplemental Resource

# Supplement 6B

## PART B: Counseling Traumatic Fistula Clients (Psychosocial Issues)

### NOTE TO TRAINERS

Supplement 6B contains a pair of activities that trainers can use to help the participants to think about what they can tell clients during counseling sessions, by focusing on helping clients to understand their emotions. All facility staff who are helping women and girls with traumatic fistula need to understand the range of emotional reactions that they may have and the key messages that they need to provide to clients to best help them in that moment.

*Time: 55 minutes*

### TRAINING TIP

Different providers attending this training will likely be working in different types of clinical settings, with varying access to the financial and human resources needed for psychosocial counseling of traumatic fistula clients and other survivors of sexual violence. Some clinics or hospitals have a special department staffed with professionals for counseling sexual violence survivors, while in other situations, a small staff must all participate in this work, regardless of previous training and access to resources. The following activities are designed to orient service providers to the main types of individual counseling that may be needed by their clients. Providers may also find appropriate opportunities to establish group counseling and/or group support activities for clients with traumatic fistula. This is discussed further in Session 9, but it will depend on the situation and may require additional skills in group facilitation. The ways in which they may already be doing this work or that they may plan to do this work in the future will vary considerably, depending on how the services are currently designed.

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

1. Ask the participants to pair up with the person sitting to their right (or left).
2. Distribute three index cards and three pieces of tape to each pair of participants.
3. Ask each pair to discuss the terms “psycho,” “social,” and “psychosocial” and to agree on one word that they feel best represents what they believe these terms to mean.
4. One of the partners of the pair should write the word “psycho” on one card, “social” on the second card, and “psychosocial” on the third card. On the back of each of these cards, ask the participants to write the word that they have identified to represent the concept.
5. After five minutes of brainstorming in pairs, invite the participants to tape their cards onto the appropriate flipchart paper.
6. Review the collection of words per category while generating a group discussion on the meaning of these three terms. Try to group words and concepts together to the extent possible.
7. Summarize the session by comparing the results with the following descriptions of the terms “psycho,” “social,” and “psychosocial”:
  - Psycho: relates to the “interior” functioning of the individual—that is, the individual’s psychological functioning
  - Social: relates to the “external world” factors that influence the individual
  - Psychosocial: relates to the well-being and psychological functions of the individual (interior) in relation to his or her social environment (exterior)

*(Adapted from: UNFPA, 2005)*

### TRAINING TIP

The intent of this activity is to help the participants think about the terms that are used every day in their work. The key concepts are more important than a specific definition, and it is important that the participants do not get distracted by discussing the finer details of one definition or another. Guide the discussion in a way that integrates the participants’ ideas with the key concepts presented in Step 1 above.

## Activity 2: Small-Group Discussion and Presentation (45 minutes)

1. Hang up prepared flipchart papers that each have a grid with two columns and 2–3 evenly spaced rows where emotions (found in Step 3 below) are written horizontally (see Supplemental Handout 6-c).
2. Divide the participants into groups of about five participants each.
3. Assign to each group an equal number of topics from the following list. (These are common emotional reactions to sexual violence that have been identified already in Session 4.)
  - Fear
  - Anguish/sorrow
  - Anger
  - Withdrawal and isolation
  - Powerlessness
  - Denial/negation
  - Guilt and self-blaming
  - Shame and feelings of dirtiness
  - Loss of self-confidence
  - Mood swings
  - Loss of self-esteem
  - Depression
  - Flashbacks
  - Nightmares
4. Ask the participants to discuss each of these symptoms and to think of strategies that they can use within a psychosocial framework to help clients understand what these feelings are and why they may be experiencing them.
5. After about 20 minutes of discussion, use the rest of the remaining time to fill in the tables written on the flipcharts previously prepared. Ask each group to share their thoughts and ideas for counseling strategies for each of the symptoms.
6. Distribute Handout 6-C: Counseling Strategies to Address Emotional Reactions to Sexual Violence.



**TRAINING TIP**

Helping clients to express themselves and their emotions is a first step in helping them to understand what has happened to them at the psychosocial level. Healing and recovery will take different forms for different people, and strategies for ongoing support are described elsewhere in this curriculum. Through this exercise, help the participants to think about what they can tell clients during counseling sessions by focusing on helping clients to understand their emotions. Also, explain that clients may experience or describe these emotional reactions at any stage in service delivery. All staff who are helping women and girls with traumatic fistula need to understand the range of emotional reactions that they may have and the key messages that need to be provided to clients to best help them in that moment.

**TRAINING TIP**

Although most traumatic fistula clients are women, extreme sexual violence also affects young girls. The counseling needs of young girls and adolescents are different from those of adult women. Additionally, the counseling needs of young girls who have been raped will change as they grow up and mature. What a child may not understand at a younger age, she may conceptualize differently when she is older; thus, her counseling needs may change over time. Handout 6-C also provides guidance on counseling strategies for young girls and adolescents as well as adults. During the discussions in this exercise, address this issue with the participants and encourage them to think about clients' needs at different ages.

*Go to page 141 in the obstetric fistula training curriculum—Part A: Overview of Counseling.*

## Supplemental Handout

# Supplemental Handout 6-c

## Counseling Strategies for Addressing Emotional Reactions to Sexual Violence

Adults and children may have experience a range of emotional reactions to sexual violence and the resulting health situations with which they live. The following list of emotional reactions and counseling strategies is based on training materials developed by the United Nations Population Fund (UNFPA) in Democratic Republic of Congo for the Joint Initiative for the Prevention of Sexual Violence and Response to the Needs and Rights of Victims/Survivors (UNFPA, 2005. *Module de formation des prestataires: volet psycho-social*. For L'initiative conjointe de prevention des violences sexuelles et de reponses aux droits et besoins des victimes/survivant(e)s. Kinshasa, DRC).

### Adults

Emotional Reaction	Strategies
Fear	Help the client ensure that her living conditions are as secure as possible. Consider survivors' fears to be legitimate and help them develop strategies that give them hope again for a normal everyday life.
Sorrow/grief	Inform survivors about the causes and manifestations of sorrow and grief, and offer strategies for managing this reaction, including relaxation techniques, physical activity, diversions, and spiritual meditation.
Anger	Help the survivor to express her anger in a setting where she is totally secure. Tell her that anger is a normal and justifiable reaction. Help the survivor to find positive and secure ways to express anger and hostility against both the attacker(s) and society in general, and to translate that energy into a personal and socially viable change.
Withdrawal and isolation	Remind the survivor that anything she says, and the services provided to her, will be kept in complete confidentiality. Help her to find support groups and other places where she can share her experiences without any risk to her safety. Encourage her to share her story with other survivors so that she knows that she is not alone. Always keep an empathetic and respectful attitude when interacting with a client who is withdrawn or seeks to isolate herself.
Powerlessness	Help the client to think about her situation in terms of the different decisions that she made and how she was able to save herself. Reinforce the important message that she is a survivor and that she has the power to be resilient in the face of the difficulties she is experiencing.

*continued on next page*

## Adults (continued)

Emotional Reaction	Strategies
Denial/negation	Explain to the survivor that all sexual violence incidents carry grave consequences and that it is important to acknowledge what has happened in order to be able to benefit from the support that is available.
Guilt and self-blaming	Let the survivor know that men, women, and children all face some risk of sexual violence and that under no circumstances is it ever the fault of the survivor. Rather, the assailant(s) is/are to blame. There is nothing that the survivor could have done to provoke or justify an attack. Insist on the fact that it is in no way the survivor's fault, but rather that it is entirely the assailant who is guilty.
Shame and feelings of dirtiness	Help the survivor to talk about the attack and assign blame and any feelings of shame to the attacker.
Loss of self-confidence	Help the survivor to rebuild her self-confidence by reminding her that the her survival of this kind of attack demonstrates her strength and great determination.
Mood swings	Inform the survivor that mood changes after this kind of experience are normal. It is an understandable response to trauma. Reassure her that the intensity of these kinds of reactions and mood changes will diminish gradually, and that many of the problems associated with the attack will be resolved with time.
Loss of self-esteem	Draw attention to the survivor's positive characteristics that she can use to overcome the effects of this ordeal.
Depression	Help the survivor to take her life back into her own hands by letting her express any embarrassment and any anger against the assailant(s), as well as the community, with respect to this experience.
Flashbacks	Tell the survivor that flashbacks are a manifestation of trauma that is neither irreversible nor a sign of insanity, but rather a natural reaction that will diminish over time. If she experiences a flashback during a counseling session, ask her to breathe deeply. Remind her that she is in the process of remembering the incident, but that she is not reliving it. Ask her to take a good look at her surroundings so that she is sure of where she is, and remind her that she is somewhere where nothing can happen to her and where no one will harm her. Encourage the survivor to talk about the flashbacks and/or make sketches of what happens during the flashbacks.
Nightmares	Inform the survivor that nightmares will decrease over time as the healing process continues. Encourage her to talk about her nightmares.

## Children and Youth

Age	Signs of Trauma	Strategies
Infant/young child (0–5 years)	<ul style="list-style-type: none"> <li>• Cries more</li> <li>• Is always frightened or sad</li> <li>• Clings to mother</li> <li>• Has nightmares and/or does not sleep</li> <li>• Is hyperactive or nonactive</li> <li>• Experiences hindrances in development</li> </ul>	<ul style="list-style-type: none"> <li>• Hold the child frequently and provide regular reassurance</li> <li>• Encourage her to draw and to talk about what has happened</li> <li>• Help her to express herself when playing alone and with others</li> <li>• Encourage parents to control their own emotions</li> <li>• Encourage playtime</li> </ul>
Child (6–12 years)	<ul style="list-style-type: none"> <li>• Cries more</li> <li>• Is always frightened or sad</li> <li>• Engages in aggressive or sexual play (e.g., plays soldier and attacks another child)</li> <li>• Is afraid to sleep in the dark</li> <li>• Becomes mute or develops eating disorders</li> <li>• Regresses</li> <li>• Has stomach complaints and/or headaches</li> </ul>	<ul style="list-style-type: none"> <li>• Hold the child frequently and provide regular reassurance</li> <li>• Encourage her to draw and to talk about what has happened</li> <li>• Help her to talk about any nightmares or flashbacks</li> <li>• Do not reprimand her if she wets the bed, but explain why this might happen and that if she continues to talk about what has happened, and when she feels more secure, this will probably stop</li> <li>• Help the child to understand the meaning of what has happened (through psychosocial education, cognitive therapy)</li> <li>• Encourage playtime</li> </ul>
Adolescent (13–18 years)	<ul style="list-style-type: none"> <li>• Does not want to talk about her feelings</li> <li>• Feels guilty about surviving when others have died</li> <li>• Plans revenge</li> <li>• Has nightmares</li> <li>• Is depressed</li> <li>• Cries and/or is preoccupied</li> <li>• Refuses to eat</li> </ul>	<ul style="list-style-type: none"> <li>• Listen carefully to her and assure her that you have time to listen</li> <li>• Help her to talk about nightmares and flashbacks</li> <li>• Encourage her to make drawings of her feelings and fears</li> <li>• Teach her relaxation strategies</li> <li>• Organize exchanges of experiences between clients, if feasible and appropriate</li> <li>• Encourage her participation in sports, dancing, walks, music, and prayer/spiritual meditation; encourage game playing</li> </ul>

## Supplemental Resource

**Part A: Overview of Counseling—Activity 2: Additional Discussion Points**

Part A in this section of *Counseling the Obstetric Fistula Client* seeks to have the participants specify the information that needs to be provided and imagine the emotions that fistula clients are likely to feel at each stage of their clinical visit. It is important to remember that women and girls who have experienced sexual violence may find certain aspects of the initial medical examination and/or traumatic fistula treatment procedures to be especially upsetting.

While each individual will react differently to the experience, providers need to be aware that in addition to any physical discomfort a sexual violence survivor may experience during a pelvic exam, the experience may evoke associations and memories of the rape event that can lead to psychological **retraumatization**. The survivor may:

- Resist the exam
- Exhibit nervous shaking or other physical symptoms of fear
- Become hostile

Remind the participants that the key to avoiding further harm to the client, and to being able to fully treat her, is effective counseling through open communication during the entire process, and reassurance of her rights to confidentiality, privacy, and dignity.

Invite the participants to discuss ways to ensure that the services they offer to sexual violence survivors do not lead to retraumatization at any stage of care.

Distribute and briefly discuss Supplemental Handout 6-d: Preparing the Traumatic Fistula Client for the Initial Physical Examination, which provides additional details on how health care providers can ensure client rights at the stage of the initial exam.

*Return to page 142 in the obstetric fistula training curriculum—Part A: Activity 2, Step 3.*

Supplemental Handout

## Supplemental Handout 6-d

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### Preparing the Traumatic Fistula Client for the Initial Physical Examination

The following guidelines are adapted from: World Health Organization (WHO) and United Nations Office of the High Commissioner for Refugees (UNHCR). 2004. *Clinical management of rape survivors: Developing protocols for use with refugees and internally displaced persons*—Revised ed. Geneva. p. 9 and p. 33.

A person who has been raped has experienced trauma and may be in an agitated or depressed state. She often feels fear, guilt, shame, and anger, or any combination of these. The health worker must prepare her and obtain her informed consent for the examination, and must carry out the examination in a compassionate, systematic, and complete fashion.

#### To prepare the survivor for the examination:

- Introduce yourself.
- Ensure that a trained support person or trained health worker of the same sex accompanies the survivor throughout the examination.
- Explain what is going to happen during each step of the examination, why it is important, what it will tell you, and how it will influence the care you are going to give.
- Reassure the survivor that she is in control of the pace, timing, and components of the examination.
- Reassure the survivor that the examination findings will be kept confidential unless she decides to bring charges against the perpetrator(s).
- Ask her if she has any questions.
- Ask if she wants to have a specific person present for support. Try to ask her this when she is alone.
- Review the consent form with the survivor. Make sure she understands everything in it, and explain that she can refuse any aspect of the examination that she does not wish to undergo. Explain to her that she can delete references to these aspects on the consent form. Once you are sure that she understands the form completely, ask her to sign it. If she cannot write, obtain a thumbprint, together with the signature of a witness.
- Limit the number of people allowed in the room during the examination to the minimum necessary.
- Do the examination as soon as possible.
- Do not force or pressure the survivor to do anything against her will. Explain that she can refuse steps of the examination at any time as it progresses.

**To prepare a child survivor for the examination:**

- As with an adult examination, a support person or trained health worker whom the child trusts should be in the examination room with you.
- Encourage the child to ask questions about anything he or she is concerned about or does not understand at any time during the examination.
- Explain what will happen during the examination, using terms the child can understand.
- With adequate preparation, most children will be able to relax and participate in the examination.
- It is possible that the child cannot relax because he or she has pain. If this is a possibility, give paracetamol or other simple painkillers, and wait for them to take effect.
- Never restrain or force a frightened, resistant child to complete an examination. Restraint and force are often part of sexual abuse and, if used by those attempting to help, will increase the child's fear and anxiety and worsen the psychological impact of the abuse.
- It is useful to have a doll on hand to demonstrate procedures and positions. Show the child the equipment and supplies, such as gloves, swabs, etc., and allow the child to use these on the doll.

## Alternative Handout

# Participant Handout 6-E

## Overview of Clinical Intake

Clinical intake for traumatic fistula clients must address both the health-related aspects of the rape incident(s) generally and the diagnosis and treatment plan for fistula. Observations documented during the clinical intake, as well as laboratory results, are an important part of the forensic evidence that a client can use if she decides to take her case to court.

The following overview of clinical intake addresses both rape and fistula. The first section, which focuses on history-taking, includes points related to sexual violence, fistula, and general reproductive health. It is divided into two parts, with the first concentrating on the information that should be documented about the sexual violence incident(s) that the client has experienced and the second focusing on the client's medical history. If the client has already provided complete information about the rape during earlier discussions with a social worker or other staff person, this part should be skipped and/or used only to follow up on any important gaps in the information needed to assist in the physical exam. It is important that the client not be asked to talk about her experience multiple times with different staff, since every retelling can be emotionally difficult for the client and can lead to retraumatization. Diagnostic criteria for vesicovaginal fistula and rectovaginal fistula based on history-taking are also provided.

The section outlining the physical exam is also divided into two sections. The first section is directed to general rape-related trauma that can be used both for ensuring full treatment of the rape survivor's physical needs and for obtaining forensic evidence. The second part deals more specifically with fistula diagnosis. Diagnostic criteria for vesicovaginal fistula and rectovaginal fistula based on the physical exam are also provided. The sections on laboratory tests and explanation, discussion, and consent integrate both sexual violence–and fistula-related concerns.

These guidelines are adapted from international standards. Providers should be familiar with any existing national protocols and make any necessary modifications to these guidelines.

## History-Taking

### Medical History

- Age, parity, and past obstetric history
- Any history of genital cutting
- Number and sex of children, dates of delivery, and their current status
- Menstrual history (last menstrual period, and whether the was client menstruating at the time of the incident)
- Evidence of pregnancy
- 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 and/or rape

### **Information Needed about the Sexual Violence Incident(s)**

- Type of physical violence (e.g., beating, biting, pulling hair, etc.) and location on body
- Use of restraints and/or weapon(s)
- Drugs/alcohol used
- Type of penetration (vaginal, anal, oral) and with what (penis, weapon, broken bottle, knife, sticks, etc.)
- Ejaculation by one or more assailants; if so, location (anal, vaginal, oral)
- After the incident, whether the survivor vomited, urinated, defecated, brushed her teeth, rinsed her mouth, changed her clothing, washed or bathed, or used a tampon or pad

*Adapted from:* WHO & UNHCR, 2004.

### **Diagnostic Criteria for Vesicovaginal Fistula**

When taking the 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:

- 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 the 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 patient has diarrhea.
- The clinical client might also have fecal incontinence due to associated damage to the anal sphincter.

## Physical Examination

The client's physical exam may be conducted 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. 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. Please see the handout on "Preparing the Traumatic Fistula Client for the Initial Physical Examination" (page 122) for further detail.

The physical exam should cover the woman's general condition, as well as any condition associated with fistula. The exam should include:

- Checking vital signs
- Noting signs of possible malnutrition or anemia
- Examining the abdomen gently

### Physical Examination for Rape Trauma (General)

The following guidelines are provided so that the client receives an adequate overall assessment of rape-related physical trauma and as a means of properly documenting any forensic evidence of the assault. More specific guidelines on the physical exam for fistula follow afterwards.

As the World Health Organization (WHO) and the United Nations High Commissioner for Refugees (UNHCR) point out (2004):

A forensic examination aims to collect evidence that may help prove or disprove a connection between individuals and/or between individuals and objects or places. Forensic evidence may be used to support a survivor's story, to confirm recent sexual contact, to show that force or coercion was used, and possibly to identify the attacker. Proper collection and storage of forensic evidence can be key to a survivor's success in pursuing legal redress. Careful consideration should be given to the existing mechanisms of legal redress and the local capacity to analyze specimens when determining whether to offer a forensic examination to a survivor. The requirements and capacity of the local criminal justice system and the capacity of local laboratories to analyze evidence should be considered.

Physical examination for rape trauma that has occurred recently is enhanced through the use of a rape kit with all of the necessary equipment and supplies for the collection of forensic evidence. The rape kit should include, at a minimum (WHO & UNHCR, 2004):

- A speculum (preferably plastic, disposable, only adult sizes)
- A tape measure for measuring the size of bruises, lacerations, etc.
- Paper bags for collection of evidence
- Paper tape for sealing and labeling containers/bags
- Supplies for universal precautions (gloves, a box for the safe disposal of contaminated and sharp materials, soap)
- Resuscitation equipment
- Sterile medical instruments (kit) for repair of tears, and suture material

- Needles, syringes
- A gown, cloth, or sheet to cover the survivor during the examination
- Sanitary supplies (pads or local cloths)
- Drugs needed for treatment of sexually transmitted infections (STIs), as per country protocol
- Emergency contraceptive pills and/or a copper-bearing intrauterine device
- Local anesthetic for suturing
- Antibiotics for wound care
- Medical chart with pictograms
- Consent forms
- Information pamphlets for the survivor's postrape care
- A safe, locked filing space in which to keep records, to maintain confidential

The following guidelines have been adapted from *Clinical management of rape survivors*, developed by WHO and UNHCR (2004). It is advised that this reference, in addition to any local protocols, be consulted for further detail.

- Although many traumatic fistula clients do not seek services for many months or even years after they have been raped, it is important to collect any evidence as soon as possible after the incident if it has happened recently.
- Systematically examine the client's body, starting with either the upper half or lower half of her body, so as to allow her to be able to leave part of her body covered while the exam is ongoing. (Do not ask the client to fully undress at any time, as this may cause her to feel vulnerable and emotionally distressed.) Look for visible marks of trauma that are consistent with what you know about the survivor's experience (e.g., bruising in specific areas, restraint marks, bites, scratches, etc.) and record your observations detailing location, color, size, and shape of any marks or wounds.
- If the client has come for services soon after the rape, collect samples of any foreign materials on the body or clothing of the survivor (e.g., blood, saliva, semen), fingernail cuttings or scrapings, hair of the assailant(s), swabs of bite marks, etc., as per local evidence collection protocols. Also, check the woman's clothing for whether it is torn or stained and for any other materials, such as grass, leaves, or soil.
- Perform an examination of the client's genital area, anus, and rectum, according to local evidence collection protocols, and mark on the examination form the location and description of any tears, abrasions, and bruises.
- If the rape occurred after such a time period that any of the above would already have healed, check for any visible scars.
- Check for signs of pregnancy.
- Document any observations in the client's medical records—which must be securely locked and completely confidential—and in a medical certificate that the survivor may take with her, according to local protocols.

## Specific Guidelines for the Examination of Children

Conduct the examination in the same order as an examination for adults. Special considerations for children are as follows:

- Note the child's weight, height, and pubertal stage. Ask girls whether they have started menstruating. If so, they may be at risk of pregnancy.
- Small children can be examined on their mother's lap. Older children should be offered the choice of sitting on a chair or on the mother's lap or of lying on the bed.
- Check the child's hymen by holding the labia at the posterior edge between the index finger and the thumb and *gently* pulling outward and downward. Note the location of any fresh or healed tears in the hymen and the vaginal mucosa. The amount of hymeneal tissue and the size of the vaginal orifice are not sensitive indicators of penetration.
- Do *not* carry out a digital examination (i.e., inserting fingers into the vaginal orifice to assess its size).
- Look for vaginal discharge. In prepubertal girls, vaginal specimens can be collected with a dry sterile cotton swab.
- Do not use a speculum to examine a prepubertal girl; it is extremely painful and may cause serious injury.
- A speculum may be used *only* when you suspect a penetrating vaginal injury and internal bleeding. In this case, a speculum examination of a prepubertal child is usually done under general anesthesia. Depending on the setting, the child may need to be referred to a higher level of health care.
- All children, boys and girls, should have an anal examination as well as a genital examination. Examine the anus with the child in the supine or lateral position. Avoid the knee-chest position, as assailants often use this.
- Record the position of any anal fissures or tears on the pictogram.
- Reflex anal dilatation (opening of the anus on lateral traction on the buttocks) can be indicative of anal penetration, but also of constipation.
- Do *not* carry out a digital examination to assess anal sphincter tone.

*Adapted from:* WHO & UNHCR, 2004.

## Physical Examination for Traumatic Fistula

- Assess the client for limb weakness, abnormal gait or mobility, or contractures
- During inspection of the genital area, inspect 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

- Conduct a digital and speculum examination<sup>1</sup> (either during the physical exam or during the preoperative period, depending on the surgeon's preferences) to detect:
  - Any other pelvic abnormality or perineal tears
  - 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<sup>2</sup>

### 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:

- 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

- 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 patient has diarrhea.
- The clinical client might also have fecal incontinence due to associated damage to the anal sphincter.
- A few clients have no symptoms.

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<sup>1</sup> Note: For the speculum examination, some surgeons will put the woman in exaggerated left-lateral position.

<sup>2</sup> If bladder stones are suspected, the health care provider can make a diagnosis 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 patient without sedation.

## Laboratory Tests

### Screening

The health care provider may use the following tests to rule out other abnormalities and to formulate a suitable treatment plan:

- Pregnancy test, if indicated and available (WHO & UNHCR, 2004)
- STI screening using samples from the vagina and anus, including the rapid plasma reagent (RPR) test for syphilis or any point-of-care rapid test; gram stain and culture for gonorrhoea; culture or enzyme-linked immunosorbent assay (ELISA) for chlamydia or any point-of-care rapid test; wet mount for trichomoniasis; and HIV test (only on a voluntary basis and after counseling) (WHO & UNHCR, 2004)
- 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 STIs
- Immunization status (check records, if available) (Any needed vaccinations should be provided at this time.)

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 patients 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), to fully evaluate the possibility of inflammatory bowel disease.
- Endoscopy with biopsies when inflammatory bowel disease is in the differential diagnosis, since endoscopy must precede any operative approach to the fistula, as the treatment depends upon the diagnosis.

## Screening Tests for Children

Testing for STIs should be done on a case-by-case basis and is strongly indicated in the following situations (WHO, 2003):

- The child presents with signs or symptoms of STI.
- The suspected offender is known to have an STI or is at high risk of STIs.
- There is a high prevalence of STIs in the community.
- The child or parent requests testing.

(Adapted from: WHO & UNHCR, 2004, pp. 34–35)

In some settings, screening for gonorrhea and chlamydia, syphilis, and HIV is done for all children who may have been raped. The presence of any one of these infections may be diagnostic of rape (if the infection is not likely to have been acquired perinatally or through blood transfusion) (AAP Committee on Child Abuse and Neglect, 1999). Follow your local protocol.

## Explanation, Discussion, and Consent

Once the results of the preliminary investigations are available, the counselor should explain to the woman (and to her partner and family, if possible and if the woman so desires) every aspect, using simple language and visual aids, of the treatment options, details of the operation and postoperative period, and possible long-term sequelae. 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

Fistula is classified in two ways: (1) by its surgical classification and (2) by the possible degree of difficulty of repair (WHO, 2006). Both classifications are based on the degree of involvement, or not, of the closing mechanism, since this has consequences for the operative technique and the prognosis for the repair.

*Surgical classification* refers to the type of surgical repair that might be required. There is no one standardized classification system for obstetric fistula, but several are frequently used. For example, one system 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.

## Classification of fistula by type of surgery required, based on anatomic/physiologic location, and by size

Type	Location
Type I	Fistula not involving the closing mechanism
Type II	Fistula involving the closing mechanism <ul style="list-style-type: none"> <li>A Without (sub)total urethral involvement               <ul style="list-style-type: none"> <li>a. Without circumferential defect</li> <li>b. With circumferential defect</li> </ul> </li> <li>B With (sub)total urethral involvement               <ul style="list-style-type: none"> <li>a. Without circumferential defect</li> <li>b. With circumferential defect</li> </ul> </li> </ul>
Type III	Miscellaneous (e.g., ureteric and other exceptional fistula)
<b>Subclassification of fistula by size</b>	
Small	<2 cm
Medium	2–3 cm
Large	4–5 cm
Extensive	6 or more cm

Source: Waaldijk, 1995.

Fistula cases are also divided into two categories based on the *degree of anticipated difficulty of the repair* (see page 133):

- 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



## 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, 2006.

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## Alternative Handout

# Participant Handout 6-1

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## Overview of Discharge and Follow-Up

The client should be counseled and assisted with:

- Identifying and making contact with community groups that work with sexual violence survivors.
- Identifying and making contact with community groups that work with women who have fistula
- 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

## 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 1–2 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 9–12 postoperatively

## *Late Complications*

- Psychosocial dysfunction
  - Many women with traumatic fistula have lived through several major traumatic events that can easily cause emotional and mental scars: rape and other forms of physical violence; loss of family members during conflict; social isolation due to rape, fistula, or both; spousal abandonment; undesired pregnancy; possible infection with HIV or other sexually transmitted infection (STI); and many other emotional stressors.
- 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.
  - Incontinence 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.
  - Incontinence 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, dyspareunia, 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, and 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.

## Sources

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Supplemental Resource

## Part B: Counseling for Fistula Clients—Activity 3, Additional Training Tip

### TRAINING TIP

Remind the participants to integrate what they have learned about clients' emotional needs and counseling strategies at different points in service delivery.

When designing the role plays, the participants should keep in mind that clients may experience psychosocial symptoms of stress at any stage of care in the role play and should imagine how this might play out in the scenario created.

Clinical intake for traumatic fistula clients must address both the health-related aspects of the rape incident(s) generally and the diagnosis and treatment plan for fistula. Observations documented during the clinical intake, as well as laboratory results, are an important part of the forensic evidence that a client can use if she decides to take her case to court. It is critical for the training participants to appreciate this.

*Return to page 146 in the obstetric fistula training curriculum—Part B: Activity 4.*

## Supplemental Resource

## Part C: Counseling Women with Special Needs—Activity 4, Additional Discussion Points

When discussing the material on counseling women with special needs, the training participants should be reminded that when working with younger clients:

- They may be especially concerned about the stigma of rape, in particular how it may relate to their future marriage prospects in societies where young rape survivors may be considered tainted and “unmarriageable.” Additionally, delaying pregnancy may not be a priority for younger clients, and for many, the question of whether there is a risk of infertility due to the fistula or to the fistula repair process weighs heavily.

*Go to page 187 in the obstetric fistula training curriculum—Session 7: Family Planning Information and Health-Related Counseling.*





## Session 7

# Family Planning Information and Health-Related Counseling

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Session 7 of *Counseling the Obstetric Fistula Client* emphasizes the information about family planning that all obstetric fistula clients must receive before they leave the service site, the importance of clients' informed choice, and personal and clinical factors that should be considered in family planning counseling for obstetric fistula clients.

These same issues are also critical for traumatic fistula clients. However, such clients also face additional health-related issues, perhaps the most serious of which are currently being pregnant as a result of rape (or being at risk of pregnancy) and having been exposed to HIV or some other STI as a result of the rape.

### NOTE TO TRAINERS

The typical traumatic fistula patient may not have been able to access health services until long after the window of pregnancy prevention has passed. However, the trainers should still consider including the topic in this session, for those instances in which it may be relevant.

To integrate the traumatic fistula information into this session, refer to the following elements in this supplement (as directed in the blue box instructions in the obstetric fistula training curriculum):

- Alternative Session 7 Overview: Session Objectives, Points to Remember, Training Methods, Materials, and Advance Preparation (pages 142–146)
- Supplemental Resource: Supplement 7A—Unwanted Pregnancy Counseling and Emergency Contraception (pages 147–151)
- Supplemental Handout 7-a: Overview of Emergency Contraception (pages 152 and 153)
- Supplemental Handout 7-b: Case Studies in Emergency Contraception Counseling (page 154)
- Supplemental Resource: Supplement 7B—Sexually Transmitted Infections and HIV Postexposure Prophylaxis (pages 155–159)
- Supplemental Handout 7-f: Questions about Sexually Transmitted Infections (page 160)
- Supplemental Handout 7-g: Overview of Counseling on Sexually Transmitted Infections (pages 161–164)
- Supplemental Handout 7-h: Postexposure Prophylaxis (PEP) for HIV Infection (pages 165–167)

## Alternative Session 7 Overview

# Session 7 Overview

## Session Objectives

As a result of this session, the participants will be able to:

- Identify related health concerns of fistula patients (e.g. unwanted pregnancy, infection with HIV and other STIs)
- Identify the psychosocial concerns of women who have become pregnant as a result of sexual violence (e.g., emotional aspects of having a child conceived from rape, fear that the child will be rejected by other family members and stigmatized by community members)
- Describe emergency contraception, including the mechanism by which it works
- Describe counseling approaches for women pregnant as a result of rape
- 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 the importance of voluntary and confidential HIV testing services
- Define postexposure prophylaxis (PEP) to prevent HIV infection and describe procedures for the administration of PEP
- List STIs that may have been passed to clients during sexual violence, and describe testing and treatment options
- Explain why some women may not be able to achieve a pregnancy following fistula repair, even if they very much want one

## POINTS TO REMEMBER

- ✓ Women and girls suffering from traumatic fistula may also experience an unwanted pregnancy and/or HIV/STI infection.
- ✓ Women and girls who have experienced traumatic fistula and are coming for health services following soon after the sexual violence event should be counseled on the possibility of unwanted pregnancy and counseled on the possibility of emergency contraception.
- ✓ All women who have had a surgical repair for 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 a client chooses a contraceptive sterilization procedure in order to prevent future pregnancies, documentation of her informed consent is required.
- ✓ Some clients may need referral for investigation and management of potential infertility. Ensuring that such couples understand how natural family planning methods work may help some who later desire a pregnancy but are unable to achieve it.
- ✓ 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 should be 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 STIs, 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.
- ✓ If HIV/STI testing and services, and PEP are offered within the same facility, staff should ensure that clients are supported in accessing these services; if not, staff should ensure that clients have full information about the possibility of HIV/STI transmission and undertake referral to the appropriate services

## Training Methods

- Presentation/discussion
- Small-group work
- Brainstorm
- Large-group work
- Case study/role play

## Materials

- Flipchart paper, easel, markers, and tape
- Overhead projector (optional)
- Copies of *Family Planning: A Global Handbook for Providers* (World Health Organization and Johns Hopkins Bloomberg School of Public Health Center for Communications Programs)
- Supplemental Handout 7-a: Overview of Emergency Contraception
- Supplemental Handout 7-b: Case Studies in Emergency Contraception Counseling
- 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
- Additional Participant Handout 7-E: Guidelines for Selecting Contraception, by Method
- Additional Participant Handout 7-F: Questions about Sexually Transmitted Infections
- Additional Participant Handout 7-G: Overview of Counseling on Sexually Transmitted Infections
- Additional Participant Handout 7-H: Postexposure Prophylaxis (PEP) for HIV Infection

## 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 for Activity 1 in Part C on page 145.
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 the participants have regarding common family planning methods.

*Individual Considerations in Family Planning Counseling  
for Clients with 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.	

*Individual Considerations in Family Planning Counseling  
for Clients with Fistula*

Case- Study Client	Counseling Situation	Considerations
	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	

8. Prepare a Counselor Script handout (one copy) with the following information to be used during Supplement 7B—Activity 3:

*Initial questions for the “counselor” to ask the “client”:*

- Can you tell me what you know about getting HIV infection?
- Have you ever heard of a medicine (postexposure prophylaxis) that is used to prevent HIV infection after rape? If so, please tell me what you know about it.
- Do you have any questions about the medicine?

*The “client” decides to take PEP and the “counselor” continues with the following:*

- It is very important that you take all of the medicine every day for all 28 days. It is also important that you take the medicine at the same time every day. Do you know why? Can you tell me what you can do to make sure that you take it at the same time every day?
- About half of the people who take the preferred PEP medicine will develop side effects such as nausea, fatigue, and headache. The symptoms are usually mild and go away after a few days. There are other, more serious side effects, such as possible damage to the liver and bone marrow, but these are very rare and we do not expect it would happen—we do not know about anyone who has experienced this with just 28 days of medicine. For the more common side effects that I have just mentioned, what might you be able to do if you experience any of them?

*Session Time (total): 4 hours, 25 minutes, to 4 hours, 40 minutes*

*Go to page 190 in the obstetric fistula training curriculum—Session 7 Training Steps.*

## Supplemental Resource

# Supplement 7A

## PART A: Unwanted Pregnancy Counseling and Emergency Contraception

### NOTE TO TRAINERS

In any setting, a certain percentage of women who have been raped will become pregnant. It is uncertain what proportion of women suffering from traumatic fistula become pregnant as a result of rape, but the possibility always exists, and it is often a major concern of clients. Supplement 7A presents a series of training activities designed to help counselors assess clients' risk of pregnancy, explore with clients the potential use of emergency contraception, and understand the potential concerns of women who have become pregnant as a result of sexual violence.

*Time: 1 hour, 25 minutes*

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

- Write the following statements on a flipchart or a transparency (or simply read the statements aloud), and ask the participants to write down on a piece of paper 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 session.

<i>Statement</i>	<i>Response</i>
Emergency contraception prevents pregnancy primarily by disrupting or damaging an existing pregnancy.	<i>False</i>
Women whose pregnancy status is unclear can still use emergency contraception pills.	<i>True</i>
The first dose of emergency contraception pills must be taken within how many hours of unprotected sexual intercourse?	<i>120 hours (5 days)</i>

### Talking Points

At the end of the session, remember to review the correct answers to these questions. This is a good opportunity to highlight the following points (adapted from: RHRC Consortium, 2004):

- Emergency contraception prevents pregnancy; it does not damage an existing pregnancy.* Emergency contraception acts by preventing the implantation of a fertilized egg. It does not cause an abortion. It is used to prevent pregnancy from happening.
- Emergency contraception is not harmful to an existing pregnancy.* If the sexual violence survivor is already pregnant, the pregnancy will not be harmed even if emergency contraception is used.

- *Emergency contraceptive pills can be started within 120 hours of unprotected sexual intercourse to prevent pregnancy.* However, the effectiveness of prevention decreases with increasing time after the incident, even within that 120-hour period. In other words, the chances that the emergency contraception will work will be lower if the pills are started later rather than earlier.

## Activity 2: Presentation/Discussion (20 minutes)

1. Present an overview of pregnancy screening (see Training Tip below), emergency contraception methods, and the mechanisms through which these methods work to prevent pregnancy after unprotected sexual intercourse (see Supplemental Handout 7-a).
2. Provide each participant with a copy of Supplemental Handout 7-a.
3. Guide a brief discussion of these terms by inviting participants to share their understanding and use of emergency contraception in their work and what they feel to be the key counseling messages.

### TRAINING TIP

In any setting, a certain percentage of women who have been raped will become pregnant. It is uncertain what proportion of women suffering from traumatic fistula become pregnant as a result of rape, but the possibility always exists, and it is often a major concern of clients. Before discussing emergency contraception options with a client, counselors can ask the following questions to determine risk of pregnancy:

1. Have you given birth in the past four weeks?
2. Are you less than six months postpartum and fully breastfeeding and free from menstrual bleeding since you had your child?
3. Did your last menstrual period start within the past seven days?
4. Have you had a miscarriage in the past seven days?
5. Have you gone without sexual intercourse since your last menstrual period (apart from the incident)?
6. Have you been using a reliable contraceptive method consistently and correctly? (Check with specific questions.)

If the answer to *all* of these questions is **no**, there is a risk of pregnancy. The counselor should check for signs of pregnancy, test for pregnancy if possible, and discuss any emergency contraception options that may be available and relevant to the client's situation. If the answer to *at least one* of the questions is **yes**, the risk of pregnancy is somewhat reduced. The counselor should still check for signs and symptoms of pregnancy, provide pregnancy testing if possible, and provide information about emergency contraception to the client, so she can make an informed decision about which method to use, if any are available and relevant to her situation.

*Adapted from:* WHO & UNHCR, 2004.



### Activity 3: Small-Group Case Studies (40 minutes)

1. Divide the participants into four groups and provide at least one copy of Supplemental Handout 7-b: Case Studies in Emergency Contraception Counseling to each group.
2. One person in each group should read the case studies to the rest of the group members. After reading each case study, and before moving on to the next, group members should discuss their recommended counseling approach to each situation, including any technical information about emergency contraception that they think would be important to discuss with the client. Ask them to focus only on the pregnancy-related concerns in this case study exercise; the participants should not go into detail about the fistula aspects at this time. One person in each group should be chosen by the group members to take notes for later presentation. (20 minutes)
3. When the groups come together after their discussion, ask one person from each group to review their counseling approach for one of the case scenarios.
4. Review each of the case scenarios and invite members of the other small groups to add their comments and suggestions.
5. Summarize the exercise with any key points that have arisen in the case study discussions.

#### TRAINING TIP

Some of the key points that participants should think about when discussing their approach to counseling the clients presented in the cases studies for Activity 3 include the following:

- How long before the woman accessed services did the incident(s) of unprotected sexual intercourse occur? This will determine whether emergency contraception is an option and will influence which emergency contraception methods could be used, if any.
- It is important that clients understand that emergency contraception prevents pregnancy. Emergency contraception will not be effective if the client is already pregnant. Pregnancy testing must be done before IUD insertion. Women who are already pregnant are not eligible for an IUD. Clients who use emergency contraceptive pills and who are later determined already to have been pregnant will not experience any harm to themselves or their fetus.
- For clients for whom emergency contraception is an option, counselors should explain the mechanisms by which it works. Counselors should also explain the side effects that clients may experience.
- In helping eligible traumatic fistula clients to choose an emergency contraceptive method, counselors should let clients know that some women may find the insertion of an IUD to be emotionally traumatic. Emergency contraceptive pills may be preferable.

## TRAINING TIP

Activities 1–3 focus on addressing the prevention of undesired pregnancy arising from sexual violence. However, many of the women and girls who suffer from traumatic fistula do not come for health services within the number of days needed to use emergency contraception and may already be pregnant by the time they arrive at a hospital or clinic. Remind the participants that pregnancy screening is part of the routine examination for clients suffering from traumatic fistula and sexual violence and should be undertaken. Women who become pregnant as a result of rape may face a number of psychosocial concerns relating to pregnancy and raising a child whose genetic father attacked her (e.g., emotional aspects of having a child conceived through a physically violent event, fear that the child will be rejected by other family members, fear that the child will be stigmatized by community members).

Since many traumatic fistula clients are not able to access help for a year or more after the incident(s), they may already be pregnant or have borne a child conceived from rape. Women in any of these situations may need additional special counseling. Activity 4 provides further training for counseling in these situations.

## Activity 4: Brainstorm (20 minutes)

1. Divide the participants into 4–5 groups.
2. Explain to the participants that there are currently no documented standards or guidelines for counseling women who have become pregnant as a result of war-related rape. During this exercise, have participants share with each other their experiences in counseling women on this sensitive topic, with the idea that sharing ideas on such a major counseling challenge will be helpful to everyone.

## NOTE TO TRAINERS

As this is a sensitive area, there may be instances in which the participants disagree with each other. Remind the participants that the goal of the exercise is to share ideas rather than determine one best approach or try to get other participants to change their approaches. Participants should be reminded to stay on track with the discussion.

3. Ask the participants to discuss with each other their experiences in counseling traumatic fistula clients and sexual violence survivors who have become pregnant as a result of rape and/or have borne children conceived as a result of rape (*10 minutes*). The participants should include the following questions in their discussions:
  - What are the concerns of women who have become pregnant as a result of sexual violence?
  - What are some positive messages to support women who have become pregnant as a result of sexual violence?
  - What are the challenges for children who have been conceived as a result of sexual violence?
  - What additional community support and follow up can be used to help women and their children who face these challenges?
4. Ask the participants to share some of key points from their discussion with the rest of the large group.
5. Use the flipchart to highlight common points and key messages.

### TRAINING TIP

In most countries where traumatic fistula occurs, abortion for any reason is illegal. Health care providers are typically forbidden from discussing abortion or offering any services to terminate pregnancy. Providers and counselors who work with traumatic fistula clients must bear in mind all local laws and regulation with regard to termination of pregnancy.

### TRAINING TIP

Pregnancy as a result of rape is not uncommon in conflict areas, and some providers describe counseling on this issue to be one of the biggest challenges in their work. There are as yet no specific standard guidelines on how to counsel clients who have become pregnant as a result of rape. Providers and counselors will develop their own approaches to this very sensitive topic when discussing with clients. Some providers have found it useful to remind women that it is not the child who bears responsibility for the trauma she has suffered and that all children have the right to care and support.

*Go to page 190 in the obstetric fistula training curriculum—Part A: Rationale.*

## Supplemental Handout

# Supplemental Handout 7-a

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## Overview of Emergency Contraception

Emergency contraception can be used to prevent pregnancy after unprotected sex. There are two main forms of emergency contraception:

1. Emergency contraceptive pills
2. Copper-bearing intrauterine device (IUD)

In the case of traumatic fistula clients of reproductive age, use of the IUD for emergency contraception is not advised. Insertion of a foreign object into an internal area of the body that has already sustained serious injury may lead to infection. Also, the IUD insertion process can be considered invasive and may cause psychological distress to the client.

Emergency contraceptive pills should be taken within 120 hours (five days) after unprotected sexual intercourse. There are two types of emergency contraceptive pills: one that contains only progestin (levonorgestrel), and one that combines estrogen (ethinyl estradiol) and progestin (levonorgestrel). Both types are available in higher doses, specifically as emergency contraception products. If these are not available, however, it is possible to use increased doses of regular oral contraceptives. The progestin-only regimen is preferred, because it has been shown to be more effective than the combined estrogen-progestin and because of a lower risk of nausea and vomiting.

Although emergency contraceptive pills are basically the same as regular oral contraceptives but at higher doses, they function differently from a regular dose of oral contraceptives. Taken at the high doses prescribed for emergency contraception, the pills prevent pregnancy by one or more of the following mechanisms (depending, it is believed, on when they are taken and the time in the woman's menstrual cycle when unprotected sexual intercourse occurred):

- Inhibiting or delaying ovulation by suppressing hormones
- Preventing fertilization by interfering with the movement of sperm or egg
- Inhibiting the fertilized egg from getting to the uterus
- Preventing implantation of a fertilized egg by making the endometrium unreceptive to implantation

All of these mechanisms prevent implantation of a fertilized egg. Emergency contraceptive pills do not damage an existing pregnancy and are not a form of abortion. The pills are most effective if they are started as soon as possible after unprotected sexual intercourse. Emergency contraceptive pills should not be used as regular contraception. Their most common side effect is nausea. Vomiting, spotting, breast tenderness, headache, dizziness, and fatigue may also occur.

It is not necessary to administer a pregnancy test before starting emergency contraceptive pills. However, if a client has already been determined to be pregnant, it is not necessary to use emergency contraceptive pills, as they will have no effect. If they are used and it is later determined that the woman is pregnant, there is no evidence to indicate that they cause any harm to the fetus or the woman.

The supplies needed to provide emergency contraception are available through both The New Emergency Health Kit 98 and The Reproductive Health Kit for Emergency Situations, available through UNFPA. (For more information, see: RHRC Consortium. 2004. *Emergency contraception for conflict-affected settings: A reproductive health response in conflict consortium distance learning module*. New York.)

Supplemental Handout

## Supplemental Handout 7-b

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### Case Studies in Emergency Contraception Counseling

Of the following case studies, numbers 2, 3, and 4 are based on case studies found in: Reproductive Health Response in Conflict (RHRC) Consortium. 2004. *Emergency contraception for conflict-affected settings: A reproductive health response in conflict consortium distance learning module*. New York, pp. 25–27.

1. Estelle is a 32-year-old woman who was raped while fleeing her village one week ago. As a result of serious injuries during the rape, she is urinating constantly and has come for help. She is also worried that she might be pregnant. How would you handle this client's situation?
2. Faith has brought her 14-year-old sister Ruth to you because Ruth was raped yesterday on her way home from school in the refugee camp. The family has not yet reported the incident. Faith wants to know if there is anything that can be done to prevent Ruth from getting pregnant. How would you handle this client's situation?
3. Marie is a 25-year-old refugee woman who took her first dose of emergency contraceptive pills six hours ago. She is very nauseated and thinks that she will vomit the second dose. Concerned, she has returned to the health facility in the camp and asks you for advice. How would you handle this client's situation?
4. Florence is a 45-year-old refugee who was gang-raped along with her daughter and two women friends while they were searching for fuel outside the refugee camp. Five days later, she has come to the health center because she has noticed that she is unable to control her urine and feces. How would you handle this client's situation?

## Supplemental Resource

# Supplement 7B

## Sexually Transmitted Infections and HIV Postexposure Prophylaxis

### NOTE TO TRAINERS

Voluntary testing and counseling for HIV is an important part of the package of services that traumatic fistula clients should receive, and it should be integrated with HIV postexposure prophylaxis (PEP) activities. Supplement 7B features some training activities related to these topics; these can be presented following the discussion of family planning, informed choice, and counseling.

However, neither the overall training curriculum nor this supplement provides detailed information about HIV testing and counseling. In most cases, health facilities that are able to offer clinical assistance to women and girls suffering from traumatic fistula will also already be offering HIV testing and counseling. However, if the participants would like more information about this important activity, the trainers should explain that other training resources concentrate on this topic and/or refer the participants to these.

*Time: 1 hour*

### Activity 1: Small-Group Work (20 minutes)

1. Divide the participants into groups of 4–5 persons.
2. Provide each group with one copy of Additional Participant Handout 7-F: Questions about Sexually Transmitted Infections.
3. Allow the groups about 10 minutes to review the questions and decide on their answers. Each group should select a spokesperson who will talk about the group's responses to the questions.
4. When the groups are ready, review the questions together in the large group, asking for feedback from the groups' spokespersons.
5. Guide a brief discussion about each question, providing clarifications as needed.
6. Provide each participant with a copy of Additional Participant Handout 7-G: Overview of Counseling on Sexually Transmitted Infections.

### Activity 2: Presentation/Discussion (10 minutes)

1. Provide each participant with a copy of Additional Participant Handout 7-H: Postexposure Prophylaxis (PEP) for HIV Infection.

2. Present an overview of PEP, using the handout as a guide.
3. Guide a brief discussion on this issue, including informed consent, and invite participants to share their understanding and use of PEP in their current work.

### Activity 3: Role Play and Group Discussion (30 minutes)

1. Ask for a volunteer from the group to play the role of a traumatic fistula patient who has come to a hospital seeking treatment after being attacked three days ago. Ask for another volunteer to play the role of a counselor.
2. Explain that the counselor will ask the client a series of questions (see below) to understand her knowledge of HIV and HIV PEP and try to provide as much information as possible to the client about PEP, side effects, the importance of adherence, and HIV testing.

*Initial questions for the "counselor" to ask the "client":*

- Can you tell me what you know about getting HIV infection?
- Have you ever heard of a medicine (postexposure prophylaxis) that is used to prevent HIV infection after rape? If so, please tell me what you know about it.
- Do you have any questions about the medicine?

*The "client" decides to take PEP and the "counselor" continues with the following:*

- It is very important that you take all of the medicine every day for all 28 days. It is also important that you take the medicine at the same time every day. Do you know why? Can you tell me what you can do to make sure that you take it at the same time every day?
- About half of the people who take the preferred medicine will develop side effects such as nausea, fatigue, and headache. The symptoms usually are mild and go away after a few days. There are other, more serious side effects, such as possible damage to the liver and bone marrow, but these are very rare and we do not expect it would happen—we do not know about anyone who has experienced this with just 28 days of medicine. For the more common side effects I have just mentioned, what might you be able to do if you experience any of them?

*Source: WHO, 2007.*



3. The “counselor” and the “client” should act out the role play, with the counselor using the scripted questions you have provided. The client will respond according to what he/she knows about answering the counselor’s questions, and the counselor will provide as much information as he/she can.
4. Ask the other participants to note to themselves additional points that they think are important to include in counseling.
5. Facilitate a discussion about counseling for PEP, providing clarifications as needed and inviting participants to share their practical experiences in this area.

### TRAINING TIP

You may want to ask for different volunteers to take on the role of counselor for different counseling segments, so that several participants have the chance to practice counseling on this subject.

The “client” may already know quite a bit about HIV infection, but the counseling scenario will vary somewhat with each client. The following are some important points that should be covered for each question:

*“Can you tell me what you know about getting HIV infection?”*

- HIV is a virus that can be transmitted between people in different ways, including sexual intercourse. AIDS is caused by the HIV virus.
- Most people who are exposed to HIV through sexual intercourse one time do not get the infection, because even if the person(s) who attacked you are HIV-positive, the virus does not always get all the way into the bloodstream. You may be exposed to the virus, but your body might be able to fight it off.
- For vaginal intercourse, the risk for becoming infected by HIV by someone who is HIV-positive is between one in 100 and one in 1,000. For anal intercourse, the risk is 1–3 per 100. HIV infection can happen in cases of forced oral sex as well, but it is very rare.
- In cases of traumatic forced sex and forced sex by multiple attackers, the chances of HIV infection increase. Even if the chances are small overall, it is still important to safeguard against HIV infection whenever possible.

*“Have you ever heard of a medicine (postexposure prophylaxis) that is used to prevent HIV infection after rape? If so, please tell me what you know about it.”*

- This medicine has been used in many situations where a person has been exposed to HIV.
- The medicine works by helping the body to fight the virus, which stops it from getting into a person’s blood stream so they do not get infected.
- Not everyone who takes the medicine gets protected, and it is not guaranteed to work. But according to research, it reduces the chances of getting HIV if the person who attacked you was HIV-positive.
- The medicine is in the form of a pill that you take every day in the morning and in the evening for 28 days. *(This may need to be modified, based on the regimen used in specific setting.)*

*(continued)*

## TRAINING TIP (continued)

- For the medicine to work, it is very important that you take it every day of the 28 days.
- About half of the people who take this medicine get side effects. These can include nausea, fatigue, and headache (depending on the regimen).
- If you decide to take this medicine, you should start right away.
- You can stop taking the medicine at any time, but you will not benefit fully from it, and if you are already HIV-positive, you might develop a resistance to the drugs that help to prevent HIV from becoming AIDS. You should contact me or another health worker here before you think about stopping the medicine before the 28 days are over.

*“It is very important that you take all of the medicine every day for all 28 days. It is also important that you take the medicine at the same time every day. Do you know why? Can you tell me what you can do to make sure that you take it at the same time every day?”*

- For the medicine to work best, it is important that the amount of it in your blood stays about the same throughout the day. That is why it is important to take it at specific times every day. For example, if you are taking the medicine twice a day, you can take it once when you get up in the morning and once before you go to bed in the evening (depends on regimen). Depending on the medicine you get, you may also be asked to take it with food, or to take it without food.
- There are some things you can do to make it easier to remember to take the pills. These are things like: using things you do every day at the same time as cues to take the pill—like brushing your teeth in the morning, or having a meal; try taking the medicine with food (if allowed) to reduce nausea; think about days when your routine is different and think of ways to make sure you can still take the medicine on time; if you are taking a pill before going to sleep, try to take it before you lie down so that you do not fall asleep before you take it; if you have a mobile phone, set the alarm for when you need to take the medicine; think about asking a trusted friend or family member to help remind you when you need to take the medicine.
- If you forget to take a dose and it is less than halfway to the time to take the next dose, you can still take it. If it is more than halfway, do not take the missed dose—wait until it is time to take the next dose. Do not take two doses at the same time to make up for a missed dose.

*“For the most common side effects (nausea, fatigue, headache), what can you do to minimize them?”*

- If you are on the preferred regimen (zidovudine and lamivudine), you can take the medication with food.
- You can also take aspirin or panadol to relieve any headaches.
- While there is nothing to do for fatigue, it is good to try to schedule your activities so that you have some periods of rest and to remember that this is temporary and a way to help make sure that you do not develop HIV, which would bring much more difficult health problems later.
- It is very possible that you will not experience any side effects, but if you have trouble taking the medication because of the side effects, come back to us and we will help you think of ways to make sure that you can stay on it for the full 28 days.

Source: WHO, 2007.

**TRAINING TIP**

Voluntary testing and counseling for HIV is an important part of the package of services that traumatic fistula clients should receive, and it should be integrated with HIV PEP activities. This training curriculum does not provide detailed information about HIV testing and counseling. In most cases, health facilities that are able to offer clinical assistance to women and girls suffering from traumatic fistula will also already be offering HIV testing and counseling. However, if the participants would like more information about this important activity, explain that there may be other trainings that concentrate on this topic and/or refer them to the following resources:

- EngenderHealth. 2008. *COPE for HIV counseling and testing: A toolbox to accompany the COPE Handbook*. New York.
- World Health Organization and Joint United Nations Programme on HIV/AIDS. 2007 (UNAIDS). *Guidance on provider-initiated HIV testing and counseling in health facilities*. Geneva.

*Go to page 211 in the obstetric fistula training curriculum—Session 8: Counseling for the Client's Family.*

Supplemental Handout

## Supplemental Handout 7-f

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### Questions about Sexually Transmitted Infections

1. What are five sexually transmitted infections (STIs) that are caused by bacteria?
2. Name an STI other than HIV that is caused by a virus. Can it be cured?
3. Which three STIs should automatically be treated with antibiotics in cases of clients who arrive to the health center within 72 hours of the rape incident(s)?
4. True or false—women often do not have symptoms for many of the common STIs?
5. Name three symptoms associated with STIs that women can experience.?
6. True or false—only those STIs that cause ulcers (sores) are associated with an increased risk of HIV infection.?
7. If left untreated, what are some of the potential effects of STIs? ?
8. What is the main side effect of the antibiotics used to treat bacterial STIs??
9. Should both adult women and young girls who have traumatic fistula be treated for STIs? Is it an issue for young girls too?
10. Why is it important for clients to be treated for STIs before fistula repair surgery?

## Supplemental Handout

# Supplemental Handout 7-g

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## Overview of Counseling on Sexually Transmitted Infections

Traumatic fistula clients are at risk of sexually transmitted infections (STIs), as are all survivors of sexual violence. Both clients who seek services immediately after the sexual violence incident(s) and those who come to the health center later should receive counseling and treatment for STIs. Those clients who come within 72 hours of the incident(s) may be treated preventively. Those clients who come after 72 hours may already be infected and can be tested for STIs if such facilities are available, or treated through syndromic management for specific infections. However, many STIs do not have symptoms, especially in women, and testing is preferred. Clients who are to undergo fistula repair should be cleared of all known infections before the operation.

Preventive treatment for clients who seek services within 72 hours of the incident(s) should receive antibiotics for gonorrhea, chlamydia, and syphilis. The prevalence of specific STIs in any specific country varies. If chancroid and/or trichomoniasis are common, clients should also receive preventive treatment for these infections. Antibiotics for STI prevention and treatment can begin at the same time as emergency contraception and/or postexposure prophylaxis to prevent HIV transmission, though doses should be spread out and taken with food to minimize nausea (WHO & UNHCR, 2004).

Counseling clients on STIs should include information about:

- What STIs are and how they are transmitted
- The common types of STIs, symptoms, treatment, and possible effects
- The relationship between STIs and the risk of HIV
- The importance of completing any prescribed treatments
- Possible transmission to sexual partners

The following points are important to cover during counseling clients on STIs (adapted from RHRC Consortium, 2004):

- STIs are among the most common health problems affecting adults worldwide.
- STIs can be transmitted via vaginal, anal, or oral sexual contact. If the client is infected and has had unprotected sex with her partner after the sexual violence incident(s), it is possible that she has transmitted the infection(s). If so, it is important that the partner(s) also be tested and treated. If the client is treated and the partner remains untreated, the client can become reinfected.
- Some STIs are caused by bacteria and can be easily treated. Others are caused by viruses and cannot be cured but may be managed.
- The most common curable STIs are syphilis, chancroid, gonorrhea, chlamydia, and trichomoniasis.
- Incurable STIs are caused by viruses (e.g., HIV, genital herpes, genital warts, and hepatitis B and C).

- STIs can have serious medical consequences, including chronic illness, death, infertility, spontaneous abortion, neonatal illness, and congenital abnormalities.
- Many STIs do not cause any symptoms. However, the following are some of the STI symptoms that can be experienced:
  - Unusual discharge from the vagina or penis
  - Pain or burning with urination
  - Itching or irritation of the genitals
  - Sores, blisters, or lumps on the genitals
  - Rashes, including those on the palms of the hands or soles of feet
  - Lower abdominal pain
  - Swelling in the groin
- Both STIs that cause ulcers and those that do not cause ulcers can increase the transmissibility of HIV through increased infectiousness and increased susceptibility.
- Effective treatment of STIs can reduce the chance of HIV infection.

The following table provides general information about the common STIs. Health care providers and counselors should refer to national guidelines for more detailed, location-specific information to determine what is most relevant in that setting, as well as treatment guidelines.

Further information on treatment options for STIs according to World Health Organization guidelines is available from WHO & UNHCR, 2004; and WHO, 2005.

## References

Reproductive Health Response in Conflict (RHRC) Consortium. 2004. *Emergency contraception for conflict-affected settings: A reproductive health response in conflict—Consortium distance learning module*. New York.

World Health Organization (WHO) and United Nations Office of the High Commissioner for Refugees (UNHCR). 2004. *Clinical management of rape survivors: developing protocols for use with refugees and internally displaced persons—Revised ed.* Geneva. Accessed at: [https://www.who.int/reproductive-health/publications/clinical\\_mngt\\_rapesurvivors/clinical\\_mngt\\_rapesurvivors.pdf](https://www.who.int/reproductive-health/publications/clinical_mngt_rapesurvivors/clinical_mngt_rapesurvivors.pdf).

World Health Organization (WHO). 2005. *Sexually transmitted and other reproductive tract infections: A guide to essential practice*. Geneva. Accessed at: [https://www.who.int/reproductive-health/publications/rtis\\_gep/index.htm](https://www.who.int/reproductive-health/publications/rtis_gep/index.htm).

## Overview of Treatable Sexually Transmitted Infections

Infection	Source	Symptoms (in women)	Possible health effects (in women)
Gonorrhea	Bacterium <i>Neisseria gonorrhoea</i>	Up to 80% of women may not experience symptoms. If symptoms appear, it is usually 2–7 days (but up to 30 days) after infection, and they include: <ul style="list-style-type: none"> <li>• Pain or burning during urination</li> <li>• Unusual vaginal discharge</li> <li>• Bleeding between menstrual periods</li> <li>• Bleeding after sexual intercourse</li> </ul>	If untreated, gonorrhea can spread in the reproductive tract and cause pelvic inflammatory disease (PID).
Chlamydia	Bacterium <i>Chlamydia trachomatis</i>	Up to 75% of women may not experience symptoms. If symptoms appear, it is usually 1–3 weeks after infection, and they include: <ul style="list-style-type: none"> <li>• Unusual vaginal discharge</li> <li>• Bleeding after intercourse</li> <li>• Bleeding between menstrual periods</li> <li>• Abdominal pain</li> </ul>	If untreated, chlamydia can lead to PID and can increase the risk of acquiring or transmitting HIV. Chlamydial infections may also lead to premature delivery and can be passed on to the baby during delivery, which can result in neonatal conjunctivitis and/or pneumonia.
Trichomoniasis	Parasite <i>trichomonas vaginalis</i>	About 50% of women experience symptoms, which occur within 5–28 days after infection and can include: <ul style="list-style-type: none"> <li>• Unusual vaginal discharge</li> <li>• Itching or burning of the vagina and vulva</li> <li>• Discomfort during intercourse or urination</li> </ul>	Research indicates that trichomoniasis might facilitate the transmission of HIV. In birth outcomes, it is also associated with premature delivery, early rupture of the membranes, and low birth weight.
Syphilis	Bacterium <i>treponema pallidum</i>	Symptoms occur in stages and can occur between 10 days and three months after infections, typically about three weeks after infection. Symptoms at different stages include: <ul style="list-style-type: none"> <li>• Primary syphilis (1–3 months): small, painless sore in the area of sexual contact, usually disappears within 4–6 weeks, even without treatment. Without treatment, it may progress to the next stage.</li> </ul>	See tertiary syphilis (previous column) for potential complications.

*continued on next page*

## Overview of Treatable Sexually Transmitted Infections (*continued*)

Infection	Source	Symptoms (in women)	Possible health effects (in women)
Syphilis ( <i>cont.</i> )	Bacterium <i>treponema pallidum</i> ( <i>cont.</i> )	<ul style="list-style-type: none"> <li>• Secondary syphilis (1–3 months): generalized skin rash that might include palms of hands, soles of feet, mucosal surfaces. Tiredness, sore throat, patchy hair loss, muscle aches, swollen lymph nodes, and fever. Symptoms may disappear within a few weeks or a year, but infection will remain (may become latent or progress to tertiary) if not treated.</li> <li>• Tertiary syphilis (2–50 years): 30% of untreated cases will reach this stage, which involves internal damage and may lead to coordination problems, paralysis, numbness, gradual blindness, dementia, joint damage, heart disease, and possibly death.</li> </ul>	
Chancroid	Bacterium <i>haemophilus ducreyi</i>	<p>Women may be asymptomatic but typically symptoms appear 3–5 days after infection (up to 14 days after infection). Symptoms include:</p> <ul style="list-style-type: none"> <li>• Painful ulcers with ragged edges on or around genitals</li> <li>• Painful swelling of lymph glands</li> <li>• Ulceration of lymph glands</li> </ul>	No systemic complications.

*Adapted from:* RHRC Consortium, 2004.



## Supplemental Handout

# Supplemental Handout 7-h

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## Postexposure Prophylaxis (PEP) for HIV Infection

Although the risk of HIV transmission during a single incident of sexual intercourse is relatively small, clients who have experienced sexual violence often have well-founded concerns about this serious potential health outcome, especially where HIV prevalence is high. The risk of HIV infection may be higher in cases of rape than in consensual sex due to physical trauma. Younger clients may also be at increased risk due to physiological immaturity (vaginal and cervix cells).

Research shows that use of a short course of antiretroviral medicines as postexposure prophylaxis (PEP) has been effective in reducing the risk of HIV infection in some cases. Evidence about the efficacy of PEP use in cases of sexual assault is not conclusive, but it is believed to be beneficial if the client is able to access health services within 48–72 hours following the rape. PEP cannot be considered 100% effective. However, traumatic fistula clients who arrive within 72 hours of the rape should be offered PEP, unless it is already known that the client is HIV-positive. In cases where the client has been raped more than once over a period of time, the 72-hour time period applies to the most recent potential exposure. If the client is already known to be HIV-positive, PEP should not be offered, as it will not have any effect and may actually increase the client's risk of developing resistance to antiretroviral therapy (WHO, 2007).

PEP therapy is recommended if:

- Less than 72 hours has passed since the most recent rape incident, the client is not known to be HIV-positive, the HIV status of the assailant(s) is either unknown or known to be positive, and the rape involved one or more of the following:
  - Vaginal or anal intercourse took place without a condom (or condom was used but broke or slipped).
  - Oral sex took place with ejaculation.
  - The blood or ejaculate of the assailant(s) came into contact with the client's mucous membrane or nonintact skin during the assault.
  - The client was unconscious at the time of the attack and is not sure about the nature of the attack.
  - The client was gang-raped.

*(Adapted from: WHO, 2007.)*

### PEP regimen

- If the client is eligible for PEP according to the criteria above, treatment (initial dose) can begin either prior to HIV testing or within an hour or two of test results, if rapid testing is available.
- The preferred PEP regimen is based on a combination of two drugs: zidovudine and lamivudine. There are other drugs that can also be taken, with lamivudine in place of zidovudine, but this depends on what is used in-country. Medical staff should consult national protocols for further detail.

- The complete dose of PEP is 28 days, and adherence is very important, as it is believed to be most effective only at the full dosage.
- There are three options for dosing:
  - Provision of starter packs of 1–7 days' worth of doses, if the client can return within 1–3 days for more complete HIV testing and counseling and to collect the rest of the medicine. This both encourages the client to return for services and minimizes waste in the case that treatment is stopped.
  - Incremental dosing, in which the client receives medicine every 1–2 weeks to encourage follow-up and minimize waste.
  - A full 28-day dose, especially if the client may not be able to come back to the hospital or clinic for follow-up.
- Side effects include nausea and fatigue. If possible, the client should also receive anti-nausea medicine.
- PEP should also be offered to younger clients (girls), taking into consideration proper dosing according to weight.
- It is safe for pregnant women to take the preferred PEP regimen. (It is contraindicated for the combination of tenofovir and emtricitabine.)

(Adapted from: WHO, 2007.)

### Key Counseling Points

The following key points should be included in counseling traumatic fistula patients about HIV and PEP:

- *HIV and the possibility of transmission.* If not already aware, the client should be informed of the possibility that she might contract HIV as a result of the sexual violence she has experienced. It is important to assess the client's understanding of HIV and AIDS and provide basic background information about HIV, as necessary. The likelihood of contracting HIV from a single incident of consensual vaginal sexual intercourse is small (estimated to be between one in 100 and one in 1,000). But the risk is real and may be increased in the type of rape that can result in traumatic fistula—that is, rape that results in internal tissue tears and open wounds, and/or rape that is perpetrated by multiple assailants.
- *Effectiveness of PEP.* The client should be informed that a 28-day course of antiretroviral therapy might prevent an HIV infection from occurring if the assailant(s) were indeed HIV-positive. PEP is not considered to be 100% effective, and it is not known how effective it is in preventing *infection after sexual intercourse, but it is believed to be beneficial.*
- *Adherence to the PEP regimen.* The first dose should be taken as soon as possible and can even be taken before HIV testing. The client should receive information about which drug regimen is being given to her, the proper daily dose, and the importance of adherence. Adherence to the prescribed regimen is important, both because it will ensure the maximum effect of prevention and because, if the client is indeed HIV-positive, the risk of resistance to treatment increases.
- *Side effects.* The most common side effects are nausea and fatigue. This can be reduced, depending on the type of drug regimen prescribed, through the prescription of anti-nausea medication and by the taking of the medicines with food.

- *HIV testing.* HIV testing is recommended, but it should not be a precondition for eligible clients to receive PEP. Repeat HIV testing and counseling is encouraged at 2–4 months after the client was exposed (assuming she has been able to access services before then) and again at 4–6 months.
- *Confidentiality.* As in all other aspects of the client's medical and psychosocial counseling, it is important to emphasize that all information about the client's situation, including test results, are kept in complete confidentiality.

## Informed Consent

Informed consent should be obtained prior to the administration of PEP. The World Health Organization/International Labor Organization guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection indicate that information that should be provided during counseling for PEP as part of the informed consent process includes the following:

- The risk of acquiring HIV infection from the specific exposure
- What is known and not known about the efficacy of PEP
- The importance of taking an HIV test and of receiving appropriate posttest counseling (although testing may be delayed if necessary)
- The possibility that they might already be infected with HIV will need to be assessed, if they have not already had an HIV test
- People already living with HIV should be referred to a local clinic for treatment of their infection, and if they had started PEP, the medicine should be stopped when the diagnosis is confirmed
- People with discordant rapid HIV test results should be offered PEP while waiting for pending laboratory-based confirmatory testing
- That PEP medication will be discontinued if their initial HIV test is positive: This medication does not work for people living with HIV and could increase the risk of drug resistance among people already infected
- The importance of adhering to medicine
- The duration of the course of medicine (four weeks)
- The common side effects that may be experienced while taking PEP medicine
- That they can stop taking PEP medicine at any time, but if they do so, they will probably not receive the full benefit of PEP if the source to which they were exposed was HIV-positive
- PEP medicine can be taken during pregnancy and may protect the woman from becoming infected with HIV after exposure
- That continuing to breastfeed while taking PEP is safe, although if women get infected by HIV while breastfeeding, the risk of transmitting HIV through breastfeeding is higher at the early stage of infection (Appropriate counseling should discuss safe alternatives to breastfeeding if they are acceptable, feasible, affordable, and sustainable.)
- That exclusive breastfeeding is strongly recommended whenever alternatives are not possible

Source: World Health Organization (WHO). 2007. *Post-exposure prophylaxis to prevent HIV infection: Joint WHO/ILO guidelines on post-exposure prophylaxis (PEP)*. Geneva. p. 21. Accessed at: [http://whqlibdoc.who.int/publications/2007/9789241596374\\_eng.pdf/](http://whqlibdoc.who.int/publications/2007/9789241596374_eng.pdf/).



## Session 8

# Counseling for the Client's Family

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Session 8 of *Counseling the Obstetric Fistula Client* focuses on the counseling needs of the families of obstetric fistula clients, with attention to the purpose of counseling for family members during each stage of service delivery, issues that can best be dealt with in joint counseling and those best addressed through individual counseling, and the employment of counseling skills for addressing family members' counseling needs.

Traumatic fistula clients present providers with a range of different psychological issues, however. While husbands and other family members can be a tremendous source of support for traumatic fistula clients, they may also experience a wide range of emotions as a result of the sexual violence perpetrated against a woman or girl. During conflict, when rape is used as a weapon of war, armed combatants sometimes rape women and girls in front of other family members as a means of further terrorizing the community and destroying the identity of men and parents as protectors.

Even when husbands and other family members have not been direct witnesses to the violence, those closest to the survivor may themselves be traumatized and be less able to provide needed emotional support and physical care-giving. Unfortunately, half or more of all married traumatic fistula patients may be abandoned by their husbands as a result of having been raped and their resulting injuries.

To integrate the traumatic fistula information into this session, refer to the following elements in this supplement (as directed in the blue box instructions in the obstetric fistula training curriculum):

- Alternative Session 8 Overview: Session Objectives, Points to Remember, Training Methods, Materials, and Advance Preparation (pages 170–175)
- Supplemental Resource: Supplement 8A: Impact of Sexual Violence and Traumatic Fistula on Husbands and Families (pages 176–178)
- Supplemental Resource: Supplement 8B: Overview of Counseling for the Client's Family [alternative/expanded version of Part A, Activity 1] (pages 179 and 180)
- Supplemental Resource: Part D Additional Points to Discuss (page 182)

## Alternative Session 8 Overview

# Session 8 Overview

## Session Objectives

As a result of this session, the participants will be able to:

- 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 for family members during each stage of service delivery (as appropriate), using communication skills to address family members' needs
- Develop case studies of clients who have been rejected by their husbands
- Develop case studies of young (girl) clients who are brought for services by parents or other family members
- Examine the ways in which sexual violence affects the family (traumatization of the family through loss and violence against loved ones) and family attitudes, misconceptions, and opinions about traumatic fistula
- Define family mediation, including how the process works

## 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.

*(continued)*

**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 provider has the opportunity to reiterate important messages to reduce the stigma of sexual violence and explain the common psychological effects of sexual violence.
  - The provider can directly counsel the client's husband about the possible transmission of HIV/STIs and other health consequences of sexual violence.
- ✓ 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.
  - Clients will feel supported by the provider in discussing the emotional aspects of sexual violence and traumatic fistula with family members.
- ✓ 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 a 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.
- ✓ If a client is not accompanied by a family member, the counselor should ask why and/or who will be able to help the client throughout the physical recovery process and reintegration into the community.

**Training Methods**

- Presentation/discussion
- Brainstorm
- Role play (*Note:* For Parts B–D, follow the general role-play guidelines provided on pages 173–174. 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).



## NOTE TO TRAINERS

### 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.

#### *Activity 1: Brainstorm/Discussion*

1. Ask the participants these questions: 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 the participants to brainstorm the range of emotions that a family member might feel. Write their 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-A: Activity 6 (page 106 in the obstetric fistula training curriculum). 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.

*(continued)*

## NOTE TO TRAINERS (continued)

### Activity 2: Role-Play Preparation (continued)

4. Ask each group to do the following:
  - Develop a 5–10-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
  - Remember to use the open-ended or feeling questions that the participants developed to address the sexuality and gender concerns.

### TRAINING 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?

(continued)

**NOTE TO TRAINERS (continued)**

- 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.

**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 Time (total): 4 hours, 35 minutes, to 4 hours, 50 minutes*

*Go to page 217 in the obstetric fistula training curriculum—Session 8 Training Steps.*

Supplemental Resource

## Supplement 8A

### Impact of Sexual Violence and Traumatic Fistula on Husbands and Families

#### NOTE TO TRAINERS

By this time in the training, the participants will have focused almost all of their attention on understanding the experiences and counseling needs of fistula **clients**. But helping the traumatic fistula client to navigate the difficult psychosocial and physical challenges that she faces necessarily involves addressing issues related to **her family**. Her family will play a critical role in the success of both her physical and psychosocial recovery.

The activity featured in this supplement is designed to help the participants shift their thinking from the client as an individual to the broader context of her family. This and the following activities in this session will give the participants an opportunity to tie the ideas and experiences generated by their earlier work in the training into the important topic of counseling for husbands and families.

*Time: 10 minutes*

#### Advance Preparation

1. Tack the three flipchart papers resulting from the “Idea Clustering” activity of Session 2, Part E (Traumatic Fistula and Psychosocial Impact at Individual, Family, and Community Levels) to either the flipchart stands or the walls of the training room, using an additional sheet of paper to cover them until they are used in Activity 1.

#### TRAINING TIP

Husbands and other family members are crucial to the experience of the traumatic fistula client and can be a tremendous source of support. At the same time, we also know that sexual violence against a woman or girl can have profound psychosocial impact on the members of her family. During conflict, when rape is used as a weapon of war, armed combatants sometimes rape women and girls in front of other family members as a means of further terrorizing the community and destroying the identity of men and parents as protectors. Even when husbands and other family members have not been direct witnesses to the violence, those closest to the survivor may themselves be traumatized and be in a weakened position to provide the emotional support and physical care giving that traumatic fistula survivors need. Unfortunately, in some cases, husbands and other family members may even reject the survivor.

*(continued)*

**TRAINING TIP (continued)**

Husbands and other family members of traumatic fistula clients likely experience a wide range of emotions, sometimes conflicting, as a result of the situation including:

*Negative emotions:*

- Guilt, anger, and/or powerlessness because they were not able to prevent the attack from occurring or protect the woman/girl
- Fear and trauma-related emotions as a result of the violence; fear of health consequences such as HIV and other STIs
- Fear that family members will experience similar attacks again in the future
- Shame, directed against the survivor, due to the social stigma associated with rape
- Disgust due to the physical aspects of the traumatic fistula injury
- Anger/resentment against the survivor for not being able to work as a result of the injuries and/or stress related to additional caretaking responsibilities

*Positive emotions:*

- Compassion for the survivor
- Sense of commitment to supporting the survivor in her recovery
- Protectiveness (taking on the role of protector)
- Empowerment in being able to help the survivor access the care she needs

It is also possible that the husband and/or other family members of the client have experienced sexual violence or other traumatic events themselves. Although the aim of providing counseling to family members lies in helping caregivers to facilitate an effective recovery for the client, it is important that providers keep in mind they may encounter caregivers with a range of emotions resulting from their own personal experiences. The job of the provider is first and foremost to address the needs of the client, but there may also be opportunities to refer family members to other services for themselves.

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

1. Remind the participants that during previous sessions, they have covered a lot of topics that focus on understanding, and responding to, the needs of fistula clients, including traumatic fistula clients.
2. Ask if any of the participants remember the Idea Clustering exercise that they did during Session 2 (Understanding Traumatic Fistula), Part E (Traumatic Fistula and Psychosocial Impact at Individual, Family, and Community Levels). Help the participants to remember what the activity was about.
3. On three new pieces of flipchart papers, ask the participants to identify different forms of psychosocial impact that traumatic fistula can have at the individual level (flipchart paper 1), the family level (flipchart paper 2), and the community level (flipchart paper 3), and write down the responses on the new flipchart papers as they are called out by the participants.

4. When the participants have finished, uncover the flipcharts on which you previously summarized the results of the Idea Clustering activity from Session 2, Part E. Lead a discussion comparing the psychosocial impact of traumatic fistula that the participants had identified at the beginning of the training and what they have discussed now during this activity.
5. Close the session with a summary of the impact of traumatic fistula and sexual violence on the family members, including husbands, of clients. Refer to the points raised in the first training tip above, emphasizing that the support of clients' family members is critical to healing and recovery and that health care providers have an important role in helping both the client and her family realize and address the client's needs.

## Supplemental Resource

# Supplement 8B

## PART A: Overview of Counseling for the Client's Family

*Time: 1 hour, 25 minutes*

### TRAINING TIP

Health care providers supporting traumatic fistula patients may encounter a variety of scenarios involving clients' families. This will depend to some extent on the client's age and whether she is married or in a relationship. For example, if the client is a young girl or an unmarried adolescent, the provider will most likely be addressing both the girl and her parents and/or grandparents or other caregiver. In some countries, minors under the age of 18 do not have legal decision-making rights over their health care, and counselors must address all concerns through the client's parents or guardians. Counselors should be familiar with the legal framework in their area and work within existing legal norms, while also respecting the rights of the child.

Women who are older and/or married might be accompanied by their husbands and/or other family members. Unfortunately, many traumatic fistula clients are rejected by their husbands due to the double stigma of sexual violence and the physical challenges that accompany the condition. Women are sometimes rejected by other family members as well. If a client is not accompanied by a family member, the counselor should investigate why, for two reasons. First, the client will require support during both the physical recovery and the community reintegration process. Second, if the client is not accompanied by a family member, it may signal family rejection and the possible need for the counselor to become more involved in helping the client to reestablish links, through family mediation. Some programs that address the medical and psychosocial needs of traumatic fistula survivors use both general counseling approaches and family mediation. Mediation may be used in cases where the client is looking for assistance in returning to her husband or other family members who have rejected her.

This training focuses on general counseling skills applied to the needs and concerns of traumatic fistula patients. Mediation is typically a much more involved process that addresses a specific aspect of the client's situation, with the objective of facilitating reconciliation and agreement with family. Mediation requires providers and counselors to have skills in communication and negotiation between two or more people and is not covered in this training. During this session, include a discussion of the differences between counseling and mediation, drawing on the experiences of any participants who may have been involved in mediation work. This can be done as you introduce the exercise and at different points when the groups are presenting their work. If possible, help the participants identify further training resources for mediation skills, while clarifying that this training will continue to concentrate on general counseling.

## Advance Preparation

1. Prepare three flipchart papers by holding them horizontally and drawing six columns on each for use in Activity 1. The headings for these columns are as follows:

<i>Possible Counseling Topics</i>					
<b>Client Group</b>	<b>Caretakers</b>	<b>Client's Physical and Psychosocial Needs</b>	<b>Caretaker's Psychosocial Needs</b>	<b>Action</b>	<b>Key Messages</b>

### Activity 1: Small-Group Work (45 minutes)

1. Introduce this exercise by explaining that (1) there are opportunities to provide counseling to clients and their husbands/families at every stage of care; (2) clients' families need counseling about the physical and psychosocial impact of traumatic fistula so that they understand what the client is going through; at the same time, they may also need counseling themselves to help address the range of emotions they might be experiencing; (3) if the counseling needs of family members are beyond what they are able to provide, providers and counselors still may be able to provide valuable information and referral to other services.
2. Ask the participants to divide themselves into three groups.
3. Explain that each group is going to discuss the counseling needs of family members for different types of clients: (1) girls and adolescents; (2) married women of reproductive age; and (3) older women. If the number of participants per group is too large to allow for meaningful work, help the participants to create two smaller groups per category of client.



4. Using the pieces of flipchart paper prepared for this exercise, ask the participants in each group to identify the possible caretakers, the range of possible counseling needs of those caretakers (including information provided to the family members about the client's physical and psychosocial situation, needs, choices, etc., and their own needs), possible actions to ensure that these counseling needs are addressed; and the key counseling messages that should be provided to that group to facilitate recovery.
5. When the groups are finished, ask that a representative from each group summarize their discussion for the rest of the participants.
6. Provide to each participant a copy of Handout 8-F and Handout 8-G from *Counseling the Obstetric Fistula Client*.
7. Facilitate a discussion about the variety of family member counseling needs that providers and counselors might encounter in their work, and possible ways to address these needs. Refer again to the differences between counseling and mediation.

*Return to page 218 in the obstetric fistula training curriculum—Part A: Activity 2.*

## Supplemental Resource

### Part D: Counseling at Discharge—Additional Points to Discuss

The discussion about clients' counseling needs at discharge should cover sexuality issues, hygiene, future pregnancies and the need for early birth preparedness, stigma, vocational skills, and possible links to community support groups, if any are available.

In addition, in the specific context of traumatic fistula, the discussion should include stigma related both to fistula and to sexual violence, as well as possible emotional responses to experiencing sexual violence that can occur long after the event. Special consideration should also be given to the situation of women whose fistula may have resulted from the pregnancy or birth of a child as a result of sexual violence.

It is important to remind the participants that partners or husbands might need counseling that addresses the following issues:

- Myths /misconceptions about traumatic fistula and sexual violence
- How to deal with depression or other emotional and physical results of traumatic fistula and sexual violence

*Go to page 233 in the obstetric fistula training curriculum—Session 9: Supporting the Fistula Client.*

## Session 9

# Supporting the Traumatic Fistula Client

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Session 9 of *Counseling the Obstetric Fistula Client* addresses the need to ensure that fistula clients receive the required level of community support, with an emphasis on organizing or developing support groups for obstetric fistula clients and knowing about the community organizations and services that are available for obstetric fistula clients so they can link discharged clients with them. Because of the circumstances of traumatic fistula clients, trainers need to plan to include a broader range of material in this training session—the importance of focusing on clients' resilience, the need to consider the ongoing counseling needs of traumatic fistula clients whose surgeries are delayed or whose fistula are determined to be inoperable, and the ways in which health care workers and counselors can support traumatic fistula clients at the community level, especially through activities with men (such as Men As Partners® [MAP] activities).

To integrate the traumatic fistula information into this session, refer to the following elements in this supplement (as directed in the blue box instructions in the Obstetric Fistula training curriculum):

- Alternative Session 9 Overview: Session Objectives, Points to Remember, Training Methods, Materials, and Advance Preparation (pages 184–187)
- Supplemental Resource: Part A: Activity 1 Additional Discussion Points (page 188)
- Supplemental Resource: Part A: Activity 3 Additional Discussion Points and Steps (page 189)
- Supplemental Handout 9-a: Examples of Facility-Based Client Support Groups (page 190)
- Supplemental Resource: Supplement 9A—Part C: Linkages with the Community (pages 191–194)
- Supplemental Handout 9-b: Examples of Community-Based Client Support (pages 195–197)
- Supplemental Resource: Supplement 9B—Part D: Involvement of Men as Partners at the Community Level (pages 198–201)

## Alternative Session 9 Overview

# Session 9 Overview

## Session Objectives

As a result of this session, the participants will be able:

- Describe the importance of focusing on clients' resilience
- Describe success stories and how to use them to assist women who are at the facility for an intervention
- Describe the ongoing counseling needs of traumatic fistula clients whose surgeries are delayed or whose fistula are determined to be inoperable
- Learn how to form client support groups within the facility
- 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)
- Identify ways in which health care workers and counselors can support traumatic fistula clients at the community level through general IEC activities and specific activities with men (i.e., MAP)
- Identify ways in which health care workers and counselors can promote MAP approaches in issues related to traumatic fistula and sexual violence at the community level

*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.
- ✓ Clients who experience long hospital stays due to difficulties in surgical procedures (i.e., the need to wait for a specialist) or to the need for multiple surgeries may have additional support needs.
- ✓ Clients who have inoperable fistula may become depressed or anxious and will need additional counseling about how to live positively with their condition and take care of themselves physically.

*(continued)*

**POINTS TO REMEMBER (continued)**

- ✓ Young girls with traumatic fistula may need to be convinced to wait until tissues have further developed for a successful fistula repair operation. The girls and/or their families may have ongoing support needs in the community before returning to the hospital for surgery.
- ✓ Depending on resource availability, providers may be able to establish literacy and skills training programs within the clinic setting to help women develop self-reliance and prepare for their return to the community.
- ✓ The sexual violence that causes traumatic fistula requires a multisectoral response (in such areas as health, justice, protection, and socioeconomic status); health care providers need to be aware of community resources outside of the health sector and work with them effectively to ensure that clients have the full spectrum of follow-up assistance they need when they go back to their communities.
- ✓ In some cases, women may feel unable to ever return to their communities. Despite limited resources, models for longer term postoperative support in facilities linked to hospitals exist.
- ✓ At the community level, men also suffer from the trauma that is cause to their loved ones who have been subjected to sexual violence. Men can be powerful supporters in efforts to address the needs of women and girls who with traumatic fistula, by helping them to gain access to services and supporting them when they return to their communities after surgery.

**Training Methods**

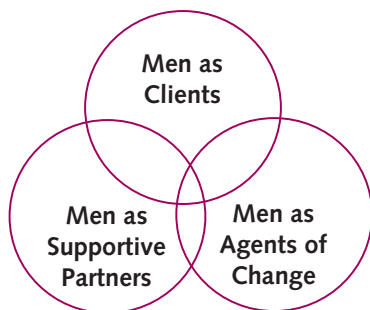
- Presentation/discussion
- Small-group work
- Large-group work
- Brainstorm
- Role play

**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)
- Supplemental Handout 9-a: Examples of Facility-Based Client Support Groups
- Participant Handout 9-A: Community-Based Organizations
- Supplemental Participant Handout 9-b: Examples of Community-Based Client Support
- 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 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. Make one copy of supplemental handouts 9-b and 9-c for each participant.
5. 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”
  - “Troubleshooting Challenges in Developing Facility-Based Client Support Groups.” [Under the title, this flipchart should have two columns: The left-hand column should have the heading “Challenges” and the right-hand column should have the heading “Troubleshooting.”]
  - “How does traumatic fistula impact the community?”
  - “How does the community impact women and girls with traumatic fistula?”
  - “What is needed at the community level to help women and girls with traumatic fistula?”
6. Prepare a flipchart titled “Approaches for Engaging Men” Under this title, draw the following diagram:



*Note:* This activity is based on materials from: The ACQUIRE Project, 2008.

7. Prepare two pieces of flipchart paper, one titled “Men as Supportive Partners” and the other “Men as Agents of Change,” and hang these on the wall so that the participants will be able to tape smaller pieces of paper to them as part of Activity 2, Part D.
8. On index cards or pieces of paper, write the following phrases (one per card/paper) for the participants to use in Activity 2, Part D.
  - a. A community health worker helps a man to find transport to a hospital where he has learned that there are doctors who can do an operation to stop his wife's incontinence.
  - b. A radio spot encourages men whose wives have been attacked by other men during conflict, or any other time, to understand that the women and girls are not at fault.
  - c. During joint counseling, a facility health care provider informs the husband of a woman with fistula that he will not be able to have sexual intercourse with her for at least three months after her operation.
  - d. A village elder counsels a man not to reject his wife whose has been raped, but to support her and her children both financially and emotionally.
  - e. A women's community group calls on the older brothers of an adolescent girl who has become incontinent after being raped by armed militiamen. They explain that their sister probably has a fistula and encourage the brothers to help her get to a hospital rather than hide her away at their grandmother's house.
  - f. A program that recruits males volunteers to advocate for legal justice for sexual violence survivors.
  - g. Men whose wives and other female family members who have been raped hold community dialogue sessions with other men to talk about the importance of not blaming women and girls for the violence they have suffered.
  - h. A theater group gives a performance about societal expectations for men as related to violent behavior, and discusses with them and advocates for change in the community.
  - i. A community organization works with men in educational sessions to identify and address negative gender norms and develop healthier and more equitable gender behaviors.
  - j. An organization conducts sessions for military men policing their communities to sensitize them to the fears that the women in their families have about being raped and asks them for assistance in helping establish protection mechanisms specifically to prevent women and girls from being raped.
  - k. Male community leaders join in organizing community sensitization on stigma related to fistula and sexual violence, urging other in the community to see women and girls who have had these experiences as survivors who help hold their communities together and who need and deserve the community's support.
9. Prepare the room so that each group can sit near its respective case-study and feelings flipcharts.
10. Gather the materials and prepare the room for practice role plays.
11. Set up the video camera and television or monitor (optional).

*Session Time (total): 5 hours, 40 minutes*

*Return to page 235 in the obstetric fistula training curriculum—Session 9 Training Steps.*

## Supplemental Resource

### Part A: Activity 1—Additional Discussion Points

An additional potential benefit of a support group is:

- Support groups offer clients opportunities to openly discuss their feelings about having experienced sexual violence and trauma.

The trainers should also ensure that the participants understand that facilities treating traumatic fistula clients will likely be treating obstetric fistula clients, and that group activities typically do not distinguish between traumatic and obstetric fistula patients. At the same time, a facility may be receiving significant numbers of women and girls who have experienced sexual violence without having developed fistula. Through facility-based group activities for women and girl survivors of sexual violence, traumatic fistula clients may find it helpful to get to know others who have had similar experiences, challenges, and emotions arising from rape, and to gain solidarity with other survivors.

*Return to page 236 in the obstetric fistula training curriculum—Part A: Activity 2.*



## Supplemental Resource

**Part A: Activity 3—Additional Discussion Points and Steps**

Training participants should be aware that in many cases, health care workers and counselors focus exclusively on the health needs of clients. While health issues are indeed the priority in the facility-based treatment of fistula, clients' needs are typically much wider.

When facilitating the discussion in this activity, the trainers should emphasize that although client support groups typically focus on peer education and emotional support around a specific health issue, traumatic fistula clients often have great difficulties in self-sufficiency and experience distinct psychosocial challenges arising both directly and indirectly from their experiences and condition. For example, in the eastern Democratic Republic of Congo, facilities specializing in the treatment of women and girls suffering from sexual violence and traumatic fistula have initiated successful client support groups with an expanded focus, including:

- Skills training and income generation
- Literacy training
- Singing and dancing groups
- Prayer groups

The trainers should also ask both the participants and the guests to comment on the possible challenges that can arise when developing facility-based client support groups (e.g., that there may be no interest in the activities, that other groups of clients may feel excluded, that there may be a lack of funding and/or difficulties in making activities sustainable, that there may be a lack of human resources and/or challenges in deciding who is responsible for what aspects of the group, etc.). As the participants and guests think of potential challenges, ask them to also talk about ways to troubleshoot by preventing or addressing problems as they arise. Write their responses in the appropriate columns on a flipchart entitled “Troubleshooting Challenges in Developing Facility-Based Client Support Groups.”

The trainers should also provide the participants with a copy of Supplemental Handout 9-a: Examples of Facility-Based Client Support Groups (next page), noting that these are examples of some approaches in established programs that can help to generate further ideas about how to build facility-based client support groups.

*Return to page 237 in the obstetric fistula training curriculum—Part A: Activity 3, Step 3.*

## Supplemental Handout

# Supplemental Handout 9-a

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## Examples of Facility-Based Client Support Groups

Clients receiving medical attention for traumatic fistula must often stay at the health facility for weeks and even months. While there are periods of time when bed rest is required, especially following surgery, clients are otherwise able to participate in group activities that can help them to return to their communities in a stronger position than when they left. Examples of facility-based client support groups that are currently in place at a number of fistula clinics include the following.

### Types of facility-based client support groups:

- Education programs (for school-age clients and/or children of clients)
- Adult literacy groups
- Skills-training programs (sewing, catering, and other productive skills)
- Income-generation training (small business skills)
- Dance groups
- Singing groups
- Group orientation on health issues
- Group orientation on human rights and legal issues

When successfully managed, facility-based client support groups can provide benefits to client by building practical skills, encouraging clients to support each other, and facilitating psychosocial healing. Adult literacy programs, for example, not only provide clients with reading skills, they sometimes represent a transformative experience of learning something new and valuable that can also instill great confidence in women whose lives had been severely disrupted by pain and shame. Dance, singing, and spiritual activities—in a group context in which women and girls can support each other and find joy in otherwise difficult times—can play a fundamental role in social reintegration.

At the same time, there are challenges to managing facility-based client support groups. To be successful, the programs cannot run on their own; they require dedicated staff to establish and manage the activities. The skills needed for this—both practical skills (e.g., teaching literacy classes and specific skills training) and group facilitation skills—are not the same as clinical or counseling skills and may require the hiring of additional staff. In addition, other resource inputs, especially for skills training programs, can become costly, and sustainability is sometimes a challenge.

## Supplemental Resource

# Supplement 9A

## PART C: Linkages with the Community

*Time: 1 hour, 25 minutes*

### Activity 1: Discussion (15 minutes)

#### TRAINING TIP

Throughout various sessions in this training, participants have brainstormed and discussed the many ways in which the issues that traumatic fistula patients have experienced are linked with their communities, and the impact of conflict-related trauma at both the individual and community levels. This part of the training helps the participants to consider the ways in which they can help ensure that communities support traumatic fistula clients, through support to community mechanisms. Before going on to the later activities, it is a useful time in the training for the participants to think about what they have already discussed in terms of traumatic fistula clients and community linkages. This will set the stage for more comprehensive discussions in the following activities. As you lead the group through Activity 1, help them to remember where the training has touched on these issues in previous sessions. For example:

- In Session 2, Part E, the participants worked on an idea clustering exercise where each person identified a form of psychosocial impact that traumatic fistula can have at the community level. Together, they generated a list of ways in which traumatic fistula is felt within the community.
- In Session 2, Handout 2-B, the participants read about the underlying social issues that increase the burden of traumatic fistula and hinder women and girls from accessing care, including lack of local services, lack of information, stigma, and insecurity.
- In Session 2, Handout 2-C and Handout 2-E, the participants read about the social consequences of traumatic fistula for clients, including stigma and social isolation, as well as ways in which traumatic fistula impacts the community—such as community feelings of guilt and powerlessness at being unable to protect women and girls, strain on local health services that may not be able to address needs, and secondary trauma for those in the community who support sexual violence survivors.
- In Session 3, Part B, Activity 3, the participants discussed a series of values statements, including attitudes that providers might have as a result of societal or community level beliefs—for example, “Women who have been raped were probably in the wrong place at the wrong time and should have been more careful to avoid being raped,” or “When women with traumatic fistula decide to file a case against the perpetrator, it puts health service providers at risk for their own personal security.”

*(continued)*

### TRAINING TIP (continued)

- In Handout 6-B: Qualities of an Effective Counselor, the participants read how individuals in a variety of functions, including community program staff, religious leaders, and professionals in legal and protection services, are all called upon to be effective counselors when interacting with traumatic fistula clients and need to have good counseling skills.
- Handout 6-C: Counseling Strategies to Address Emotional Reactions to Sexual Violence points out that one way to help a woman who has experienced sexual violence and who is depressed is to encourage her to express any embarrassment as well as any anger that she might have against the community with respect to her experience and how she has been treated.
- Handout 6-K: Overview of Discharge and Follow-Up points out that counselors should help clients to identify and make contact with community groups that can help them.
- In Session 7, Part A, Activity 4, the participants brainstormed about the community support and follow-up that can be used to help women who have become pregnant as a result of sexual violence.
- Session 8, Part A, Activity 1 asks the participants to identify different types of psychosocial impact that traumatic fistula can have on the community

1. Ask the participants to think back on the training sessions that have already been completed and write down three key points they have thought about with regard to traumatic fistula and the community. One point should answer the question: How does traumatic fistula impact the community? The second point should answer the question: How does the community impact women and girls with traumatic fistula? The third point should answer the question: What is needed at the community level to help women and girls with traumatic fistula?
2. Invite the participants to share their answers to the first question and write down responses on a piece of flipchart paper with the title "How does traumatic fistula impact the community?" Do the same with the other two questions, noting responses on the appropriate flipchart papers.
3. Facilitate the discussion by reminding the participants of any issues that were raised in the previous sessions (see Training Tip above for references to earlier activities that have raised relevant issues).
4. Add any additional issues to the appropriate flipcharts and ensure that they are hung so that all participants can easily view them.
5. Summarize by reviewing the main points that arose during the discussion.

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

1. Divide the participants into four groups and provide each group with 3–4 pieces of flipchart paper.
2. Ask each group to identify at least two “key issues” from the lists generated in Activity 1. One key issue should come from the list “How does traumatic fistula impact the community?” and the other should come from the list “How does the community impact women and girls with traumatic fistula?” The issues that the groups select should be those that they think can be addressed at least in part at the community level. After a brief discussion within the groups to decide which two issues they want to work with, ask a representative from each group to identify which they have selected, to ensure (if possible) that the groups are all working on different key issues.
3. Instruct the groups that for each key issue, they should discuss the following questions and write down their responses on a piece of flipchart paper:
  - a. What is the key issue?
  - b. What is the impact of this issue on the traumatic fistula client?
  - c. What is a solution to this issue? (Small-group members might think of several possible solutions, but they should focus only on one.)
4. On a second piece of flipchart paper, ask the participants to turn the paper horizontally and make three columns of even width across the page. At the top of the left-hand column, have the participants write: “Who in the community needs to be involved?” At the top of the middle column, they should write: “What can they do?” At the top of the right-hand column, they should write: “What help is needed from the facility?”
5. Ask the participants to brainstorm several points (i.e., possible responses to the questions) within each column.
6. Invite one group member from each group to present to the rest of the participants the results of this exercise for each of the two issues they selected.
7. Facilitate a brief summary discussion by noting that:
  - a. The physical and psychosocial healing of traumatic fistula clients continues well past the point of discharge, and the success of their efforts in treating traumatic fistula clients depends in part on what happens at the community level.
  - b. There are many different ways in which providers and counselors can help communities to support women and girls who have experienced traumatic fistula.

## TRAINING TIP

While explaining Activity 2 to the participants, you may want to provide an example of how to do the exercise. If necessary, use the following example to help clarify the exercise:

Flipchart 1:

- What is the key issue? *Women are not able to access services because they are unaware that services exist to repair fistula.*
- What is the impact of this issue on the traumatic fistula client? *Women suffer for too long with the condition and treatment may become more difficult.*
- What is a solution to this issue? *Help women learn about and access services.*

Flipchart 2: (paper is turned to be horizontal)

Who in the community needs to be involved?	What can they do? (community-level)	What help is needed from the facility?
<ul style="list-style-type: none"> <li>• Community health workers</li> <li>• Village leaders</li> <li>• Community women's groups</li> </ul>	<ul style="list-style-type: none"> <li>• Sensitize the population about fistula and the availability of services</li> <li>• Help specific women get transport to the hospital and link up with services</li> </ul>	<ul style="list-style-type: none"> <li>• Health education for community leaders about traumatic fistula</li> <li>• Community sensitization</li> <li>• Transport reimbursement for fistula clients or mobile services to help bring clients to the hospital</li> </ul>

*Return to page 239 in the obstetric fistula training curriculum—Part C: Activity 1.*

## Supplemental Handout

## Supplemental Handout 9-b

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### Examples of Community-Based Client Support

Community support for women and girls recovering from traumatic fistula is a crucial part of long-term recovery. In many conflict-affected countries, there are successful programs that focus on community resources to support women and girls who have experienced sexual violence and traumatic fistula. Many other examples exist in countries that have not been directly affected by conflict but that are addressing gender-based violence issues at the community level. Community-based client support can take the form of medical support, economic activities and training, legal support, psychosocial activities, advocacy, and community sensitization. The following are some examples, with web site and contact information where additional information can be obtained.

#### Examples of Community-Based Support Programs for Traumatic Fistula Clients

##### *Heal Africa (Democratic Republic of Congo, North Kivu)*

Through its hospital services in Goma, Heal Africa offers comprehensive medical and counseling care to women and girls with traumatic fistula. As well, Heal Africa has a large structure of community-based programs throughout North Kivu Province. This is organized in part through Neahmiah Committees and the Guéri Mon Peuple program for support of sexual violence survivors. The Neahmiah Committees are comprised of community and church leaders, local authorities, social workers, and medical personnel in each of the province's nine health zones. Heal Africa staff train committee members to help the most vulnerable individuals in their communities, through sensitizing communities about different health issues including sexual and gender-based violence, and they provide information about where sexual violence survivors can go for help. The Neahmiah Committees also are instrumental in helping fistula patients and sexual violence survivors reintegrate into the community after they have received care at Heal Africa. Additional information can be found at: <http://healafrika.org/cms/programs/post-conflict-rebuilding-the-nehamiah-initiative/>.

##### *Panzi Hospital (Democratic Republic of Congo, South Kivu)*

Panzi General Referral Hospital, located in Bukavu, manages a fistula repair program that provides a range of medical and counseling care services to women and girls who have experienced sexual violence. Panzi Hospital also manages a mobile clinic that conducts outreach activities in the surrounding areas about twice a week, to inform communities about the availability of services, to screen sexual violence survivors for medical and psychosocial needs, to facilitate the transport of patients as needed, and to provide follow-up attention to women and girls after they have returned to their communities. The mobile clinic is staffed with a doctor, a nurse, a psychologist, and two social assistants, and they mainly go to areas where the partner organizations have identified women who have experienced rape. More information about Panzi Hospital can be found at [www.panzihospitalbukavu.org/about.php?weblang=1/](http://www.panzihospitalbukavu.org/about.php?weblang=1/).



### *Promotion Pour la Santé et Agroélevage au Mainema (PROSAEMA) (Democratic Republic of Congo, Maniema)*

Through PROSAEMA's Maternité Sans Risque (MSR) project, located in Kindu, Maniema Province, medical and other staff provide fistula repair services and counseling to sexual violence survivors from the area. The 20 staff members at the MSR hospital (including one physician who is trained in fistula repair surgery) offer sexual violence patients services in four main areas: medical treatment, psychosocial care, legal assistance, and economic and reintegration activities. Patients' psychological needs are addressed by nurses who are educated by various counseling nongovernmental organizations (NGOs) and by the government health services who provide training on reintegration for sexual violence survivors. Staff also provide important counseling services and work closely with other local NGO partners for psychological support referrals. More details about PROSAEMA's work are available in French from online resources, including the following:

[www.unfpa.org/emergencies/symposium06/docs/dayonesessionfourjeanpascalmanga.doc](http://www.unfpa.org/emergencies/symposium06/docs/dayonesessionfourjeanpascalmanga.doc)

A conference presentation is available at: [www.raiseinitiative.org/conf2008/#programme](http://www.raiseinitiative.org/conf2008/#programme). Additional information may also be obtained through: [prosaema@yahoo.com](mailto:prosaema@yahoo.com).

### **Examples of Community-Based Support Programs for Survivors of Sexual and Gender-Based Violence in Conflict Settings**

#### *Community Services Initiative (Guinea)*

In 2001, the American Refugee Committee (ARC) worked with community members to establish the Community Services Initiative (CSI) for survivors of sexual and gender-based violence at refugee camps in Guinea. Among other activities, the program included services in skills-building and income generation (training grants in soap-making, tie-dying, needlework, and tailoring; academic scholarships; business management skills, etc.), medical case management and health access, and gender-based violence community education and awareness-raising with security forces, camp committee members, NGO workers, health workers, and others. A complete description of how this community-based service program for survivors of sexual and gender-based violence was established is at: [www.arcrelief.org/site/PageServer?pagename=programs\\_GBV\\_bookspage](http://www.arcrelief.org/site/PageServer?pagename=programs_GBV_bookspage).

#### *Synergie des Femmes pour les Victimes des Violences Sexuelles (SFVS) (Democratic Republic of Congo)*

SFVS is a Goma-based network of 35 local and international organizations that help sexual violence survivors regain physical and emotional health, sensitize communities about the consequences of sexual violence, and ensure psychological, economic, and legal follow-up services for women and girls who have experienced sexual violence. There are four programmatic areas: psychosocial assistance; medical care; legal advocacy; and socioeconomic support. Activities are undertaken by a network of community-based counselors throughout North Kivu who help women to access services by putting them in touch with SFVS partners and focus sensitization efforts through formal community network groups comprised of village leaders, chiefs, nurses, teachers, youth leaders, and church leaders. Field-based counselors also play a key role in what is noted as one of the biggest challenges: social and economic reintegration of sexual violence survivors once they return to their communities. More information about SFVS can be found at [www.raisehopeforcongo.org/synergiedesfemmes](http://www.raisehopeforcongo.org/synergiedesfemmes) and through direct contact at [synergie\\_sfvs@yahoo.com](mailto:synergie_sfvs@yahoo.com).



### *Women in Crisis Movement (Sierra Leone)*

The Women in Crisis Movement was established in 1997 as a small community effort to provide food, clothing, shelter, and support for women and girls traumatized by conflict, who were coming to the capital city from all over Sierra Leone. With headquarters in Freetown, the organization today continues to provide shelter and has also established a vocational training center with training opportunities in sewing, poultry farming, handicrafts, and literacy. For more information, contact Women in Crisis through e-mail at [womenicm@yahoo.com](mailto:womenicm@yahoo.com), or read more about their programs at [www.un.org/works/OLD/women/women5.html](http://www.un.org/works/OLD/women/women5.html) and in the United Nations Population Fund's publication *Programming to Address Violence Against Women: 10 Case Studies*, available at [http://www.unfpa.org/upload/lib\\_pub\\_file/678\\_filename\\_vaw.pdf](http://www.unfpa.org/upload/lib_pub_file/678_filename_vaw.pdf).

### *Women's Legal Aid Centre (WLAC) (Tanzania)*

The WLAC has been active for 18 years in addressing issues related to women's legal rights, including counseling and legal advice to women and girls who have survived sexual violence. The organization is also active in advocacy work for legislative and policy reform that supports the rights of women and girls in Tanzania. Through the project Access to Justice for Refugee Women and Girls, WLAC has been providing service to women and girls in four refugee camps in western Tanzania. More information about WLAC is available at [www.tanzania.go.tz/population/ngos.html](http://www.tanzania.go.tz/population/ngos.html).

## **General Information on Community-Based Approaches to Sexual and Gender-Based Violence**

### *United Nations Population Fund (UNFPA)*

UNFPA has supported many community-based initiatives in working to prevent and respond to sexual and gender-based violence, including in conflict-affected communities. Organizing community-based support can be challenging for a number of reasons. UNFPA has collected advice on culturally sensitive programming approaches that provides tips on “working from within” through the perspectives of individuals working on this issue around the world. More information is available at [www.unfpa.org/endingviolence/html/tips/tips.html#1/](http://www.unfpa.org/endingviolence/html/tips/tips.html#1/).

### *A Guide to Monitoring and Evaluation of NGO Capacity Building Interventions in Conflict Affected Settings (JSI Research and Training Institute)*

In partnership with the Reproductive Health Response in Conflict (RHRC) Consortium, JSI Research and Training Institute has worked with community-based organizations and local NGOs in almost 20 conflict-affected countries to advance services in reproductive health and gender-based violence to women and girls at the community level. This guide provides an overview of challenges in community capacity-building efforts and important information on monitoring and evaluation of program activities. More information is available at [www.rhrc.org/resources/JSI\\_ASTARTE\\_monitoring\\_evaluating\\_ngo\\_capacity\\_building\\_in\\_conflict\\_guide.pdf](http://www.rhrc.org/resources/JSI_ASTARTE_monitoring_evaluating_ngo_capacity_building_in_conflict_guide.pdf).

Supplemental Resource

# Supplement 9B

## PART D: Involvement of Men as Partners at the Community Level

### NOTE TO TRAINERS

Given the critical role that men may play in the physical and emotional recovery of fistula clients (particularly traumatic fistula clients), this section also includes a training supplement on the approaches that might be used to engage men in addressing the needs of traumatic fistula clients at the community level. Supplement 9B presents a series of activities devoted to exploring approaches for engaging men, based on EngenderHealth's Men As Partners® approach to male engagement.

*Time: 45 minutes*

### Activity 1: Discussion (15 minutes)

1. Facilitate a group discussion to review what the participants have earlier discussed about what traumatic fistula clients might need from the men in their families in order to recovery physically and emotionally. For example:
  - Emotional support (not to be blamed for what has happened, not to be rejected)
  - Help in accessing services (learning about availability of services, encouragement to get help, assistance with transport to services)
  - Understanding about medical issues related to fistula sexual violence (e.g., the possibility of infection with HIV or other STIs, the need for abstinence during the postoperative recovery period, the need to avoid heavy labor, the need for family planning, and the need to have any future deliveries at a health facility)
2. Ask the participants to think about and discuss what traumatic fistula clients might need from men at the community level. Some possible needs include:
  - The need to feel safe/protected from recurrence of sexual violence
  - The need to feel like they are part of the community and accepted
  - Help from men in fighting community norms and perceptions about sexual violence survivors and traumatic fistula
  - The involvement of men in legal and justice issues

3. Ask the following open question: “What approaches can be used to engage men in addressing these needs?” and note any responses. Invite any participants who have worked in efforts to engage men in the needs of clients who are sexual violence and/or traumatic fistula survivors to share some of their experiences.
4. Summarize the discussion by pointing out that traumatic fistula clients need men to be engaged in addressing their needs both at the individual and community levels, and that there are different approaches to support male involvement, to be reviewed in the next activity.

### TRAINING TIP

Because of the gendered nature of sexual violence and traumatic fistula, it is possible that participants in the discussion session on what clients need with regard to male involvement will want to focus on the need to stop sexual violence. Community organizations in many countries are starting to look at how to involve men in the prevention of sexual violence and make male involvement an important part of programming in gender-based violence. (Men and boys may also be subjected to sexual violence.) For the purposes of this training, however, try to guide the discussion toward ways in which men at the community level can help women and girls with traumatic fistula specifically to access the services they need and find community acceptance after they return from the hospital. Participants who are especially interested in male involvement in gender-based violence at the community level and work to change gender norms and address the needs of male sexual violence survivors will find additional resources and ideas at the following web sites:

- [www.engenderhealth.org/our-work/gender/menengage.php](http://www.engenderhealth.org/our-work/gender/menengage.php)
- [www.mencanstoprape.org/](http://www.mencanstoprape.org/)
- [www.preventgbvafrica.org/content/work-men-gender-equality](http://www.preventgbvafrica.org/content/work-men-gender-equality)
- [www.mensresourcesinternational.org/template.php?page=resources](http://www.mensresourcesinternational.org/template.php?page=resources)

## Activity 2: Discussion/Large-Group Work (30 minutes)

1. Explain that the information in this discussion and the exercise you are about to facilitate come from the EngenderHealth curriculum *Engaging Men and Boys in Reproductive Health in Conflict and Emergency Settings*. As you lead this discussion using the points highlighted below, refer to the prepared flipchart “Approaches for Engaging Men” and note that for the purposes of the exercise, the participants will be focusing on Men as Supportive Partners and Men as Agents of Change. Discussion points include:
  - Programs, in general, have used three main approaches to engage men. These are men as clients, men as supportive partners, and men as agents of change.
  - These approaches have been used more for reproductive health programs, but they are applicable to gender-based violence programs, especially the approach focusing on Men as Agents of Change.
  - The three approaches are illustrated as three intersecting circles because the approaches are not mutually exclusive. Ideally, to the extent feasible, programs should try and implement as many of the approaches they can in the work that they do.

### *Men as Supportive Partners*

- Under this approach, programs focus on the positive influence that men can have on women's sexual and reproductive health (including fistula repair), since men play a major role in decision making, planning, and resource allocation.
- Under this approach, men are seen as allies and resources in improving reproductive health as a result of their engagement in a variety of areas—maternal health, family planning, neonatal care, and HIV and AIDS
- Many of these programs take into account the gender inequities that constrain health, but they do not always explicitly implement activities to address them. These programs could be more effective if they explicitly address gender inequities.

### *Men as Agents of Change*

- Programming under this approach is more transformative, as the focus is on explicitly addressing gender norms that put women and men at risk.
  - Programs ask men to examine gender norms that negatively affect their lives and those of their partners and families. Men are then asked to develop healthier alternatives. Therefore, many programs seeking to involve men in improving reproductive health outcomes and preventing gender-based violence use this approach.
  - Under this approach, an implicit assumption is that more progressive norms around masculinity and gender will translate into improved reproductive health outcomes and gender-based violence prevention. Many programs are starting to illustrate that this does actually happen.
  - Programs that focus on “men as agents of change” are often the most intensive and difficult to carry out because they ask men to make individual changes in an unsupportive environment.
  - A few programs using this approach are now asking men to catalyze and engage with other men in their communities in promoting gender equity, including in relation to reproductive health and gender-based violence prevention.
2. After the presentation, explain that the next activity will highlight for the participants some of the ways in which each of these approaches have been or can be used in different conflict phases. Each participant will receive one or more sheets of paper listing a possible activity that engages men. Each activity can fall under either of the two categories—Men as Supportive Partners, or Men as Agents of Change.
  3. Each participant is to place the sheet of paper under one of the flipcharts posted—Men as Supportive Partners or Men as Agents of Change—depending on which they think it best fits under. Shuffle the sheets of paper to make sure that the activities for each approach are not grouped together, and randomly distribute one or more of the sheets of paper to each participant.
  4. Ask the participants to walk up to the wall, take a few pieces of tape, and post the sheets of paper where they think they belong. Remind them that there may be a few that could be placed under different approaches, which highlights the fact that interventions often use multiple approaches to engage men.

5. Once all sheets are posted on the wall, review them with the participants and move any that the group feels should be changed to a different approach.
6. Conclude the activity by discussing the questions below.
  - What did they think of the approaches to engage men that were presented?
  - Are these approaches that can be applied to their work?
  - Did the interventions provide them with ideas about male engagement activities? If so, which interventions might they implement in their program?

Source: The ACQUIRE Project, 2008, pp. 25–31.

*Go to page 247 in the obstetric fistula training curriculum—Session 10: Clinical Practicum.*



# Session 10

## Clinical Practicum

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The steps related to the clinical practicum described in the obstetric fistula counseling curriculum do not need any specific supplemental or alternative material to be added to address traumatic fistula, but if relevant, the trainers should remind the participants of the main points they have learned about the special counseling needs of women who have been traumatized, should related issues arise during the practicum.





# Session 11

## Supporting the Provider

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Before concluding the workshop, we feel that, having discussed how to support the traumatic fistula client and her family, it is crucial to address supporting the **provider**. Therefore, at the start of the session titled “Workshop Wrap-Up” in the obstetric fistula counseling curriculum, you should consider adding the supplemental material included here, which is designed to help providers manage their stress, avoid burnout, and cope with the psychological toll of dealing with trauma.

To integrate the traumatic fistula information into this session, refer to the following elements in this supplement (as directed in the blue box instructions in the Obstetric Fistula training curriculum):

- Alternative Session 11 Overview: Session Objectives, Points to Remember, Training Methods, Materials, and Advance Preparation (pages 206–210)
- Supplemental Resource: Supplement 11A: Overview of Provider/Counselor Challenges and Impact of Working with Traumatic Fistula Clients (pages 211–217)
- Supplemental Handout 11-a: Overview of Burnout, Secondary Traumatic Stress, and Vicarious Traumatization (pages 218–222)
- Supplemental Handout 11-b: Symptoms of Stress and Trauma (page 223)
- Supplemental Handout 11-c: Job Stress (pages 224 and 225)

Additionally, please refer back to Session 1 in this supplement, for the following:

- Alternative Appendix B—Pretest/Posttest on Fistula Counseling (pages 9–11)
- Alternative Appendix C—Pretest/Posttest on Fistula Counseling Answer Key (pages 15–17)

## Alternative Session 11 Overview

# Session 11 Overview

## Session Objectives

As a result of this session, the participants will be able to:

- Define burnout, secondary traumatic stress, and vicarious traumatization
- Explain the potential emotional impact to providers of supporting the needs of women and girls who have experienced sexual violence
- Discuss the importance of supporting providers who are caring for traumatic fistula clients
- Identify ways in which providers can be supported
- Discuss training follow-up plans
- Evaluate the effectiveness of the workshop in achieving its objectives
- Share closing thoughts and impressions

## POINTS TO REMEMBER

- ✓ Providers working with traumatic fistula patients may experience security threats as a result of their work.
- ✓ Burnout can occur to any provider and is “the cumulative psychological strain of working with many different stressors,” leading one to feel gradually worn down over time. It can be caused by the emotional drain from empathy, a difficult client population, long hours with few resources, ambiguous success, unreciprocated giving, and feelings of failure to live up to one’s own expectations for making positive change. It can result in depression, cynicism, boredom, loss of compassion, and discouragement (adapted from: U.S. Department of Veterans Affairs National Center for PTSD, 2007).
- ✓ Secondary traumatic stress can occur when a provider develops symptoms similar to clients as a result of working with individuals who have been traumatized. These symptoms include: hyperarousal, intrusive symptoms, avoidance or emotional numbing, anxiety, and depression (adapted from: U.S. Department of Veterans Affairs National Center for PTSD, 2007).
- ✓ Vicarious traumatization refers to “*permanently, transformative, inevitable changes that result from doing therapeutic work with trauma survivors.*” These are emotional changes that the provider may experience relating to the way in which the provider sees himself or herself. Vicarious traumatization can negatively affect the provider’s ability to maintain a sense of self and sense of groundedness, inner connection to others, feelings of personal worth, and ability to tolerate the emotional reactions of one’s self and others. It can result in providers becoming judgmental, tuning clients out, having a reduced sense of connection with loved ones and colleagues, feeling angry, losing hope, becoming overinvolved in the problems of others, creating overly strict boundaries, becoming overprotective, and avoiding social and work contact (adapted from: U.S. Department of Veterans Affairs National Center for PTSD, 2007).

(continued)

**POINTS TO REMEMBER (continued)**

- ✓ All providers who work directly with traumatic fistula clients are at risk of burnout, secondary traumatic stress, and vicarious traumatization, including counselors, physicians, nurses, and others.
- ✓ Some providers may themselves be trauma survivors, which can increase their ability to empathize with clients but at the same time may raise the risk of emotional stress.
- ✓ Many of the symptoms of work-related stress can directly and negatively impact the quality of care that clients receive. For example, stress can result in behavioral symptoms among staff, including aggression or anger toward clients, which can be damaging to the treatment and recovery process.
- ✓ Supervisors must understand the levels of emotional impact that providers can experience, recognize the signs and symptoms of stress among providers working with traumatic fistula clients through supervision, and support providers in addressing stress.
- ✓ Methods to help providers reduce or avoid the negative emotional impact of their work include (*adapted from: Vann, 2002*):
  - Meeting individually with providers (asking questions, listening, observing, advising, teaching, coaching, and mentoring) and conducting performance reviews
  - Debriefing providers in connection with especially difficult cases
  - Holding regular group meetings for providers
  - Developing policies and procedures to ensure staff security
  - Developing policies to set professional boundaries, including time off
  - Modeling positive behavior
  - Rotating staff through different functions, to allow for change of responsibilities
  - Engaging in regular group activities or events designed for relaxation and social support, including group physical exercise
- ✓ Providers who may need professional help with emotional stress should be supported in efforts to access appropriate care.

**Training Methods**

- Warm-up
- Discussion
- Presentation
- Paired group work
- Small-group work
- Individual work

## Materials

- Flipchart paper, easel, markers, and tape
- Supplemental Handout 11-a: Overview of Burnout, Secondary Traumatic Stress, and Vicarious Traumatization
- Supplemental Handout 11-b: Symptoms of Stress and Trauma
- Supplemental Handout 11-c: Job Stress
- Appendix B: Posttest
- Participant Handout 11-A: Home Site Implementation Plan
- Appendix J: Workshop Evaluation Form
- Certificates of attendance for the participants
- Refreshments

## Advance Preparation

1. Prepare a flipchart using the objectives of this session.
2. Prepare a flipchart with the title “Burnout” and the following text underneath:

### *Burnout*

“The cumulative psychological strain of working with many different stressors, leading one to feel gradually worn down over time.”

Emotional drain from

- Empathy
- Difficult client population
- Long hours with few resources
- Uncertain success
- Unreciprocated giving
- Failure to live up to one's own expectations for making positive change

Can result in depression, cynicism, boredom, loss of compassion, and discouragement.

3. Prepare a flipchart with the title "Secondary Traumatic Stress" and the text:

*Secondary Traumatic Stress*

Can occur when a provider develops symptoms similar to clients as a result of working with individuals who have been traumatized. These symptoms include:

- a. Hyperarousal
- b. Intrusive symptoms
- c. Avoidance or emotional numbing
- d. Anxiety
- e. Depression

4. Prepare a flipchart (or a pair of flipcharts) with the title "Vicarious Traumatization" and the following text:

*Vicarious Traumatization*

*"Permanent, transformative, inevitable changes that result from doing therapeutic work with trauma survivors."*

Emotional changes the provider may experience that relate to the way the provider sees himself or herself.

Impacts:

- Sense of self and sense of groundedness
- Inner connection to others
- Feelings of personal worth
- Ability to tolerate the emotional reactions of oneself and others

*Vicarious Traumatization (part 2)*

Providers may:

- Become judgmental
- Tune out
- Have a reduced sense of connection with loved ones and colleagues
- Feel anger, loss of hope
- Become overinvolved in the problems of others
- Create overly strict boundaries, become overprotective
- Avoid social and work contact

5. Prepare a flipchart “Stressors and Resources” with a table like the one below:

<i>Stressors and Resources</i>		
	<b>What gives me stress? Major Stressors</b>	<b>What gives me strength? What makes me feel good? Resources</b>
What I can control	e.g. Thinking about what I need to do at home, worrying about my children, wanting to help everyone	e.g. Meeting with friends and neighbors, taking a long walk, playing with my children, being able to help traumatic fistula clients
What I can't control	e.g. Conflict and war where I live, constant changes in the organization that I work for, the high number of clients that I have to work with every day	e.g. My boss is in a good mood, seeing a positive change in the way that the community addresses sexual violence survivors and their needs

*Adapted from:* IASC and Global Protection Cluster on Gender-Based Violence, 2010.

6. Cut two long strips of paper, about six inches wide, from the length of a flipchart paper. Fasten the top and bottom of the strips together with tape so that it can be worn as a sash. Use markers to decorate the sash with the words “Super Stress Buster” (for use in Part B, Activity 3).
7. Make enough copies of Appendix B, Handout 11-A, and Supplemental Handouts 11-a, 11-b, and 11-c, for distribution to the participants.
8. Send invitations to guests.
9. 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.
10. Ask the participants to select a representative to speak on their behalf.
11. Prepare a certificate of attendance for each participant.
12. Review Appendix J: Workshop Evaluation Form and make one copy for each participant.
13. Plan follow-up efforts.

*Time: 5 hours and 10 minutes; 30 minutes for closing ceremony, depending on local protocol*

*Go to page 267 in the obstetric fistula training curriculum—Session 11 Training Steps.*

## Supplemental Resource

# Supplement 11A

## NOTE TO TRAINERS

This session provides a series of training activities intended to help the participants understand the risk of cumulative psychological strain (“burnout”) and secondary traumatic stress (which can occur among providers when they work with many traumatic fistula clients).

## PART A: Supporting the Provider

*Time: 25 minutes*

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

1. Explain to the participants that up until now, all of the activities in this training have focused on helping clients. But providers can only help clients and provide quality services when they are best able to handle the stresses that go along with this kind of work.
2. Read the following statements aloud and ask participants who have ever had the experience or thought to raise their hands (if they feel comfortable doing so). Make a mental note of any trends (i.e., statements that almost everyone identifies with, or statements that no one identifies with).
  - Most days when I go to work, I am tired.
  - Sometimes, when I hear the stories of traumatic fistula clients and others who have experienced sexual violence, I think about something that has happened to me or someone who I know.
  - There have been times when clients tell me things that make me sad or worried.
  - I spend most of the time trying to solve people’s problems and I am not always sure it is doing any good.
  - I don’t really know what I’m supposed to think—if I sympathize too much with the situation, it is painful and I can get overinvolved, but if I don’t sympathize enough, I might not give the client the support she needs.
  - We need more help from our supervisors to help us with the difficult cases, but they are always busy.
  - Some days I wonder how much longer I can do this work.

3. Next, read the following statements aloud and ask participants who have ever had the experience or thought to raise their hands (if they feel comfortable doing so).
  - I may have my own problems, but I am happy when we can help others to solve theirs.
  - When I go home at the end of the day, I can usually “switch off” from the day and get some rest.
  - I really appreciate the other staff where I work. We support each other, and this is a source of strength.
  - The lives of traumatic fistula clients whom we can help are changed forever; for many, it means that they get their lives back, and that is worth all of the hard work.
  - The clients are usually very grateful for the assistance we give, and it feels good to have your work appreciated.
  - I think I am good at what I do.
  - The work that we do at the hospital (clinic) is helping to rebuild the country, and it gives me hope.
4. Briefly summarize any trends you may have noticed in the participants' responses and point out that counseling traumatic fistula clients can be a mix of highs and lows. Invite the participants to offer any other observations to the group, and explain that in the following activities, you will help them to think more specifically about the impact of their work on their own lives and the ways in which they can take care of themselves and each other as they do this important work.

## Activity 2: Discussion/Presentation (15 minutes)

1. Ask the participants if they have already heard the terms “burnout,” “secondary traumatic stress,” and “vicarious traumatization.” Start with the term “burnout,” and ask the participants what they understand this term to mean. Note key concepts on a piece of flipchart paper. Follow this with “secondary traumatic stress,” and note the participants' responses on a separate piece of flipchart. Do the same with “vicarious traumatization.”
2. Hang the prepared flipchart(s) with the heading “Burnout” and read the definition out loud (or ask one of the participants to read it aloud), noting that this and the other definitions you will present come from a factsheet called “Working with Trauma Survivors: What Workers Need to Know,” which was developed by the United States Department of Veterans Affairs National Center for Post-Traumatic Stress Disorder. Point out any ways in which the comments offered by the participants differed from or were similar to this definition.
3. Do the same with the remaining two flipcharts.
4. Explain that there is not necessarily a specific progression from burnout to secondary traumatic stress to vicarious traumatization. Rather, these conditions differ somewhat and have different symptoms. Emphasize that individuals react individually to their circumstances and that the same type of work may have a different impact on different people. Although there is no “right” or “wrong” way for people to be, each of these conditions can have serious consequences for providers/counselors, as well as for their clients, work colleagues, friends, and family. These individuals may become hurt, worried, and confused about the emotional and behavioral changes that they perceive, and the providers/counselors



must be aware of their reactions and take steps to take care of themselves and seek additional help from trusted colleagues and friends, if needed.

5. Provide each participant with a copy of Supplemental Handouts 11-a: Overview of Burnout, Secondary Traumatic Stress, and Vicarious Traumatization, and 11-b: Symptoms of Stress and Trauma. Review Supplemental Handout 11-b with the group and point out that as providers/counselors working with traumatized clients, they may recognize some of the symptoms of stress. Emphasize that there are ways to address these issues, both individually and together with colleagues and friends.

## PART B: Managing Stress and Preventing Burnout

*Time: 1 hour, 25 minutes*

### Activity 1: Paired Group Work (30 minutes)

1. Ask the participants to pair up with the person sitting to their right, who will be their partner for this exercise.
2. Using Supplemental Handout 11-c: Job Stress, ask that one person “interview” his or her partner and that they brainstorm together any ways in which they can remove or reduce job stress. When the first person has finished analyzing their job stress, the partners should switch roles.
3. When the participants have finished, ask them to return to the main group and invite any participants to share what they have found out about job stress in their lives and changes that they could make to reduce stress.

(Source: The Headington Institute, [www.headington-institute.org/Default.aspx?tabid=1302](http://www.headington-institute.org/Default.aspx?tabid=1302))

### Activity 2: Discussion (35 minutes)

1. Explain to the participants that dealing with survivors of sexual violence and being exposed regularly to accounts of sexual violence can be very difficult and can affect all of us, regardless of the type of work we do. Therefore, it is very important to protect ourselves and to develop tools to care for ourselves and our colleagues. Before we talk about self-care, we first need to think about things in our lives that cause stress (stressors) and things that make us feel good and/or give us strength (resources).
2. Post the flipchart “Stressors and Resources” on the wall. Ask the participants to take a blank piece of paper and to copy the table, but to leave the appropriate squares blank so they can write about their own stressors and resources. Ask them to think about things that cause stress in their daily life and work and activities or facts that make them feel good, making a distinction between what they can control and what they cannot control. Point out the examples in the table that you have earlier written on the flipchart paper. Ask the participants to also write down some of the symptoms they experience when they are feeling stressed (e.g., headache, stomach ache, difficulty concentrating, etc.).

3. Give the participants some time (5–10 minutes) to fill in their table. When everyone has finished, invite a few participants to give feedback about how they filled in their table and what they see as their signs of stress.
4. Conclude by emphasizing that it is important for us to be aware of the stressors to which we are exposed and to recognize possible signs of stress. In addition, emphasize the many positive methods and resources that we can use to combat stress in our lives.

*(Adapted from: IASC and Global Protection Cluster on Gender-Based Violence, 2010)*

### **Activity 3: Small-Group Work** (35 minutes)

1. Divide the participants into small groups (4–5 people). Give every group index cards.
2. Ask the participants to think about strategies that they use to minimize the impact of stressors or activities that are a resource to them. Tell them to write this “Stress Buster” on an index card (for example: talking to colleagues about what I find difficult at work; exercising; praying; going to see my mother and father; taking a long walk, etc.).
3. Instruct the group to place all of the index cards on the floor and then choose what they consider to be their group's best “Stress Buster.”
4. Ask the inventor of the best stress buster in every group to come forward for the election of the “Super Stress Buster.”
5. Ask the rest of the participants to vote for “the super stress buster” by applauding; whoever gets the loudest applause gets to wear the “Super Stress Buster” sash.
6. Briefly review the other stress busters that were identified in the groups. Ask how these strategies can be effective in dealing with stressors, especially those generated by working with survivors.

*(Adapted from: IASC and Global Protection Cluster on Gender-Based Violence, 2010)*

## **PART C: Self-Care**

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*Time: 50 minutes*

### **Activity 1: Brainstorm/Discussion** (10 minutes)

1. Point out to the participants that as health care providers and counselors, whose job it is to take care of other people every day, it may be difficult to ask others for help in coping with stress.

2. Ask the participants to think about the reasons why they might be reluctant to ask others for help when they feel emotionally overwhelmed by their work, or for any other reason.
3. Facilitate a brief discussion, noting down key issues on a piece of flipchart paper. Look at the Training Tip below for additional ideas to share with the participants. Ask if they agree that they and/or other providers/counselors could have these beliefs, and discuss how these beliefs might undermine their well-being.
4. Conclude by emphasizing that providers and counselors do important work, but it can only be done well when they themselves enjoy a healthy well-being. The stress and burnout that providers and counselors may sometimes experience are natural reactions to the situations to which they are exposed every day. They deserve support when it is needed, and they should not feel badly if they are overwhelmed at times. It is more important to recognize when they need help from others and know how to ask for it.

### TRAINING TIP

To help the participants brainstorm reasons why they may be reluctant to ask for help in coping with stress, share with them the following list of 10 beliefs that prevent helpers from getting help:

#### **Ten Beliefs That Prevent Helpers from Getting Help!**

1. We believe that we should not experience personal problems...that we know better!
2. We view personal problems as a sign of inadequacy or failure.
3. We think that there is no safe place for us to get help.
4. We should be aware of all helping resources for all problems.
5. We have helping skills and can take care of ourselves.
6. We often intellectualize and/or disassociate from the emotional impact of our problems.
7. We often counsel family, friends, and significant others...a violation of boundaries.
8. We feel responsible for and often take the blame if a family member or significant other has a personal problem.
9. We feel embarrassed to seek help from fellow professionals.
10. As a result of the above, we often wait longer than others to let people help, and we often sabotage our own treatment.

(Source: FHI, RHRC Consortium, and IRC, no date)

## Activity 2: Small-Group Work (20 minutes)

1. Introduce this exercise by pointing out to the participants that it is easier to ask for help when one knows what kind of help to ask for. This exercise will help the participants think about how their organizations and work environments can support them.
2. Divide the participants into 4–5 groups. Give each group a piece of flipchart paper and ask each participant to describe for the others in the group one way in which his or her organization helps its providers/counselors to address job-related stress. Ask for one person in each group to write down the responses on the flipchart. Next, ask that each participant identify at least one way in which they wish their organization supported its providers/counselors in addressing stress. These should also be written on the same flipchart under a separate section or on a different piece of flipchart paper.
3. Reconvene the entire group and ask a representative from each small group to explain to the rest of the participants his or her group's "current practices" for what their organizations currently do and "wish list" of things they would like their organization to do.
4. Write each of the responses on separate pieces of flipchart paper (one for current practices, another for the wish list). Facilitate a discussion about the relevance of the current practices and whether people find that they are helpful, as well as the relevance and feasibility of the wish list ideas.
5. Conclude by saying that the ideas generated from this exercise are ideas that they can take back to their organizations and discuss with their staff and management when they sense an opportunity for their organization to improve the ways in which they help staff better manage work-related stress. Explain that contributing to positive change at the organizational level is also a way of caring for themselves.

### TRAINING TIP

Supervision and staff peer groups are two ways in which organizations can help providers and counselors get not only technical support, but also emotional support. Burnout is caused in part by a feeling of not being able to accomplish everything that is needed, which can lead to feelings of inadequacy and low-self esteem. Good staff supervision, which offers concrete, nonjudgmental advice on how to address work challenges and encouragement of efforts, can greatly help staff recognize their own accomplishments and feel supported. Good staff supervision also involves establishing an environment that promotes openness between providers and counselors and their supervisors, so that staff feel secure in talking about stressors such as the caseload without fearing poor results on their job evaluations or other negative feedback.

Peer support groups can be organized through regular meetings where staff help each other think through solutions to challenging cases, congratulate each other on their successes, and encourage each other to keep working through the tough spots.

Supervision and staff peer groups are likely to be ongoing in many of the organizations where the participants work. If the participants do not raise this as a current practice, ask them to discuss it as a possible way in which the organization can help them. If these mechanisms are seen as inadequate because they do not exist or are not functioning, encourage the participants to think of how to ask the appropriate people in their organizations, including supervisors, to make the system work better.

(Source: MacGregor, 2008)

### Activity 3: Individual Work/Discussion (20 minutes)

1. Ask the participants to look again at the table they made during the exercise in Part B, Activity 2.
2. Ask the participants to write down the outline of a “Self-Care Plan”. Suggest that they write on a piece of notebook paper possible strategies for coping with the stressors they listed. Ask them to think about individual strategies, culture-specific coping mechanisms, social support mechanisms, and organizational aspects. Suggest that they also think about strategies for enhancing their physical well-being, their emotional well-being, their intellectual well-being, and their spiritual well-being.

*The questions below can be used as guidance:*

- What activities would help you to relax, get some distance from your work, or help you not to think about work when you are at home?
  - What can you change so that uncontrollable stressors in your life become more controllable?
  - How can you deal with the uncontrollable stressors?
  - Where can you seek social support?
  - To whom would you go to share experiences related to caring for survivors of sexual violence?
  - Which organizational and environmental changes would help you to deal with stress?
  - How can your organization best support you? What can you do to initiate changes? How can you discuss this within your organization?
3. Ask the participants to think about who they would choose as a “stress buddy”—someone who is close to them, with whom they can discuss their self-care plan, and who could help them take the initiative to deal with stress. For example, the stress buddy could be another participant in the training or a colleague, friend, or supervisor.
  4. Invite the participants who want can say something about their self-care plan if they would like to share any of their ideas with the other participants.
  5. Encourage the participants to store their self-care plan at home or in their office, and suggest that they occasionally review it as a way of monitoring whether they are taking care of their own needs.
  6. Conclude by reminding the participants that they are at risk of burnout and of different forms of stress because of the important work they do, but that there are many ways in which they can take care of themselves and ask for help when it is needed.

*(Adapted from: IASC and Global Protection Cluster on Gender-Based Violence, 2010; and FHI, RHRC Consortium, and IRC, no date)*

*Go to page 267 in the obstetric fistula training curriculum—Session 11 Training Steps: Activity 1.*

Supplemental Handout

# Supplemental Handout 11-a

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## Overview of Burnout, Secondary Traumatic Stress, and Vicarious Traumatization

Due to the emotionally demanding nature of their work, providers and counselors who work with traumatized clients are at risk of burnout, secondary traumatic stress, and vicarious traumatization. The U.S. Department of Veterans Affairs has a long history in research on posttraumatic stress disorder and other mental health issues related to trauma. Other organizations that work with humanitarian workers offer similar definitions.

Counselors and providers are at risk for all of these conditions, though whether any specific individual will develop burnout, secondary traumatic stress, or vicarious traumatization depends on a number of factors, including an individual's personality, the availability of resources, and the use of coping mechanisms, as well as the specific characteristics of the work environment and job demands. There is some overlap in the types of symptoms experienced as a result of these three conditions, but they are distinct, as the following definitions help to point out. Ultimately, it is important for each individual to be aware of the stressors in their lives, their own personal reactions to different forms of stress, and the types of resources they can use to reduce the impact of work-related stress on their health and well-being.

### Definitions

#### Burnout

The term “burnout” has been applied across helping professions and refers to the cumulative psychological strain of working with many different stressors. One of the key characteristics of burnout is that it results from exposure to different types of stress over time (cumulative stress). It often manifests itself as a gradual wearing down over time.

The factors contributing to burnout include:

- Professional isolation
- Emotional drain from empathizing
- A difficult client population
- Long hours with few resources
- Ambiguous success
- Unreciprocated giving and attentiveness
- A failure to live up to one's own expectations for effecting positive change

The symptoms of burnout include:

- Depression
- Cynicism

- Boredom
- Loss of compassion
- Discouragement

(Source: U.S. Department of Veterans Affairs National Center for PTSD, 2007)

A similar definition of burnout is offered by The Headington Institute, an organization that specializes in providing psychological and spiritual support to those working in humanitarian and disaster settings worldwide ([www.headington-institute.org](http://www.headington-institute.org)).

They refer to burnout as “a process that involves a gradual exposure to a job strain that results in exhaustion, feelings of cynicism and detachment from the job, and a sense of ineffectiveness and lack of accomplishment.” Signs of burnout in an individual include:

- Feeling exhausted, depleted, and “used up”
- Feeling detached and/or emotionally numb and callous
- Having a reduced sense of accomplishment, purpose, and meaning connected with work
- Having a sense of negativity, cynicism, and blame
- Doubt one’s self and feeling incompetent, overwhelmed, or helpless
- Experiencing a decline in performance and productivity at work
- Feeling unappreciated
- Feeling “used” and angry
- Expressing increased impatience, irritability, and conflicts in relationships
- Mistrusting colleagues’ motives and actions
- Feeling depressed

(Source: The Headington Institute, no date)

## Secondary Traumatic Stress

While people in a variety of situations can experience burnout over time, individuals who work directly with people who have been traumatized may be at risk for experiencing trauma symptoms similar to those felt by the clients they care for. The U.S. Department of Veterans Affairs describes secondary traumatic stress as follows:

The term “Secondary Traumatic Stress” has been coined by various authors to describe professional workers’ subclinical or clinical signs and symptoms of posttraumatic stress disorder (PTSD) that mirror those experienced by trauma clients, friends, or family members. While it is not recognized by current psychiatric standards as a clinical disorder, many clinicians note that those who witness traumatic stress in others may develop symptoms similar to or associated with PTSD. These symptoms include:

- Hyperarousal (heightened reactivity—startle, heart rate, pulse)
- Intrusive symptoms

- Avoidance or emotional “numbing”
- Anxiety
- Depression

(Source: U.S. Department of Veterans Affairs National Center for PTSD, 2007)

Another set of symptoms associated with secondary trauma (and with critical stress incidents) is offered in the training manual *Caring for Survivors of Gender Based Violence in Emergencies* (IASC and Global Protection Cluster on Gender-Based Violence, 2010).

Signs of critical incident stress and secondary traumatization include:

- Taking your work “home” with you: This means that even when you are not at work, when you are home or with your own family, you are unable to stop thinking about work.
- Experiencing sleeplessness.
- Feeling very emotional during or after working with a survivor.
- Having a sense of generalized anxiety.
- Feeling overwhelmed, like there is no way you can cope with what is happening around you.
- Feeling incompetent, like you can no longer accomplish what you once did well.
- Experiencing listlessness, low-grade depression, and an inability to feel happy or sad, just muted or numb.
- Having intrusive thoughts of patients, families, and extremely stressful events: dreams, nightmares, daydreaming, recurring images, vivid mental replaying of a client's trauma.
- Feeling angry at survivors, families, the system, one's self and/or staff/culture.
- Being hyperaroused, or overreacting to insignificant events (especially at home).
- Having revenge fantasies.
- Reliving haunting memories of one's own terrifying events.
- Experiencing emotional detachment to significant others (such as numbing, flat affect [see below], or loss of humor).

*Flat affect* refers to a change in a person's emotional response, wherein he or she expresses no emotion, no matter what he or she experiences.

### **Vicarious Traumatization**

Vicarious traumatization differs from secondary traumatic stress in that it involves not just symptoms of traumatic stress, but more fundamental changes in the individuals who work with traumatized populations.

The following information, provided by the U.S. Department of Veteran Affairs, helps show the distinction.

The term “vicarious traumatization” was coined by Pearlman and Saakvitne (1995) to describe “those permanently transformative, inevitable changes that result from doing therapeutic work with trauma



survivors.” In their research, they noted that a number of changes were common among mental health workers who had clients who were trauma survivors. The changes were considered not pathological (as is the case with secondary traumatic stress), and were seen instead as normal cognitive or emotional changes relating to how the mental health worker felt and thought about himself or herself. The changes were cumulative as, over time, the mental health workers worked with several trauma survivors. The changes were also pervasive in their effects on an individual's life. They tended to occur more often in highly empathic, sensitive individuals, those with a previous history of trauma, and newer therapists.

Vicarious traumatization can detrimentally affect one's:

- Relationship with meaning and hope
- Ability to get one's psychological needs met
- Intelligence
- Willpower
- Sense of humor
- Ability to protect oneself
- Memory/imagery
- Existential sense of connection to others
- Self-capacities, including:
  - The enduring ability to maintain a steady sense of self
  - Tolerance for a range of emotional reactions in one's self and others
  - A sense of inner connection to others
  - A sense of self as viable, worth loving, deserving
  - A sense of self that is grounded

A number of behavioral changes may result from vicarious traumatization, including:

- Becoming judgmental of others
- Tuning out
- Having a reduced sense of connection with loved ones and colleagues
- Becoming cynical or angry and losing hope or a sense of meaning
- Developing rescue fantasies, becoming overinvolved, and taking on others' problems
- Developing overly rigid, strict boundaries
- Feeling heightened protectiveness as a result of a decreased sense of the safety of loved ones
- Avoiding social contact
- Avoiding work contact

(Source: U.S. Department of Veterans Affairs National Center for PTSD, 2007.)

Another description of vicarious trauma (FHI, RHRC Consortium, & IRC, no date) again points to inner changes of individuals who experience vicarious trauma. Vicarious trauma is described as follows:

“A change in a service provider’s inner experience as a result of empathic engagement with survivors of trauma and hearing their story. Changes that occur in the service provider’s physical, emotional, and/or behavioral states as a result of exposure to traumatic stories or events.”

This resource also identifies the causes of vicarious trauma and some ways to address the vicarious trauma, as follows:

### ***Causes of Vicarious Trauma***

- Exposure to stories of trauma
- Desire to help/change survivor’s situation
- Feeling powerless when a service provider does not see positive changes in the survivor’s situations
- Overidentification with survivors
- Belief that we have the power to change the survivor’s situations

### ***Dealing with Vicarious Trauma***

Some ways in which people have found it helpful to prevent and manage vicarious trauma include:

- Awareness—being attuned to one’s needs, limits, emotions, and resources; practicing self-acceptance
- Balance—maintaining balance among activities, especially work, play, and rest
- Connection—maintaining supportive relationships; communication is part of connection and breaks the silence of unacknowledged pain; these connections help prevent isolation and increase validation and hope.

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## Supplemental Handout

# Supplemental Handout 11-b

## Symptoms of Stress and Trauma

Stress and trauma, due to any causes, can affect people in a number of different ways. The following table, designed by The Heddington Institute, provides a list of physical, mental, emotional, spiritual, and behavioral symptoms associated with stress and trauma. It is a useful resource to look at if you are worried that you or a colleague might be suffering from stress or trauma.

Physical	Mental	Emotional	Spiritual	Behavioral
Sleep disturbances	Difficulty concentrating	Mood swings	Feelings of emptiness	Risk taking
Headaches	Confusion	Overemotional	Loss of meaning	Over- or underreacting
Stomach upsets	Disorganized thinking	Irritability	Discouragement	Hyper-alertness
Fatigue	Forgetfulness	Emotional numbness	Loss of hope	Listlessness and apathy
Inability to rest	Difficulty making decisions	Anger	Loss of sense of purpose	Aggression
Changes in appetite	Dreams or nightmares	Depression/sadness	Doubt	Withdrawal and isolation
Rapid heart rate	Intrusive thoughts	Anxiety/apprehension	Anger at God	Compulsive behavior
Rapid breathing			Loss of a sense of connection	Increased conflict in relationships
Being easily startled			Guilt	
Muscle tremors			Cynicism	Increased smoking and/or drinking and/or substance abuse

(Source: The Heddington Institute, Pasadena, CA. Accessed at: [www.headington-institute.org/Portals/32/resources/Signs%20and%20symptoms%20of%20stress.pdf](http://www.headington-institute.org/Portals/32/resources/Signs%20and%20symptoms%20of%20stress.pdf))

## Supplemental Handout

# Supplemental Handout 11-c

## Job Stress

### Analyze Your Job Stress

1. Take an average day. Write down a list of average tasks and make notes on your routine and tendencies (i.e., what do you always do first, do you spend the same amount of time on it every day, what do you do next, etc.).
2. One of the key steps in managing your work stress is knowing where that stress comes from. So think about the information you have noted down in a couple of ways:
  - What is your general strategy in the way you organize and approach your work?
  - What is really dragging you down (e.g., is it a type of work or a time of day)?
  - Do you dread particular types of tasks and put them off?
  - Do you feel overwhelmed by some tasks?
  - Do you feel sleepy at the same time every day?
  - Do you have trouble getting started in the morning, or plugging in again after lunch?
  - Where are you consistently wasting time (e.g., the way you read and answer e-mails? procrastinating at the end of the day before you leave the office...)?

Check off any of the items below that you feel a major source of stress:

- |  |  |
|--|--|
| <input type="checkbox"/> Work overload (too much to do)                    | <input type="checkbox"/> Lousy pay                                   |
| <input type="checkbox"/> Work underload (too little to do)                 | <input type="checkbox"/> Excessive travel                            |
| <input type="checkbox"/> Too much responsibility                           | <input type="checkbox"/> Limited chance for promotion or advancement |
| <input type="checkbox"/> Too little responsibility                         | <input type="checkbox"/> Prejudice because of race/sex/religion      |
| <input type="checkbox"/> Dissatisfaction with your current role and duties | <input type="checkbox"/> Problems with boss/management               |
| <input type="checkbox"/> Poor work environment (danger, noise, etc.)       | <input type="checkbox"/> Problems with client                        |
| <input type="checkbox"/> Long hours  | <input type="checkbox"/> Problems with coworkers/staff               |
| <input type="checkbox"/> Lack of positive feedback/recognition             | <input type="checkbox"/> Office politics                             |
| <input type="checkbox"/> Job insecurity                                    | <input type="checkbox"/> A grueling commute                          |

3. Ask yourself to what extent you can remove, or at least reduce the impact of that stress? Brainstorm how would go about doing that. Realistically, in some cases you will not have the ability to eliminate some of the sources of stress at work. You may still be able to modify them somewhat, or change your level of exposure to them. Focus on what you can control.

(Source: The Headington Institute, Pasadena, CA. Accessed at: [www.headington-institute.org/Default.aspx?tabid=1302](http://www.headington-institute.org/Default.aspx?tabid=1302))



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